

AMENDED IN SENATE JUNE 13, 2016

AMENDED IN ASSEMBLY APRIL 14, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

## ASSEMBLY BILL

No. 1605

---

**Introduced by ~~Committee on Budget (Assembly Members Ting (Chair), Travis Allen, Bigelow, Bloom, Bonta, Campos, Chávez, Chiu, Cooper, Gordon, Grove, Harper, Holden, Irwin, Kim, Lackey, McCarty, Melendez, Mullin, Nazarian, Obernolte, O'Donnell, Patterson, Rodriguez, Thurmond, Wilk, and Williams)~~**  
***Committee on Budget (Assembly Members Ting (Chair), Bloom, Bonta, Campos, Chiu, Cooper, Gordon, Holden, Irwin, McCarty, Mullin, Nazarian, O'Donnell, Rodriguez, Thurmond, and Williams)***

January 7, 2016

---

~~An act relating to the Budget Act of 2016. An act to amend Section 100504 of the Government Code, to amend Sections 1324.9, 120955, 120960, 130301, 130303, 130305, 130306, 130309, 130310, and 130313 of, to add Section 125281 to, to add Part 6.2 (commencing with Section 1179.80) to Division 1 of, to add Part 7.5 (commencing with Section 122450) to Division 105 of, and to repeal Sections 120965, 130307, and 130312 of, the Health and Safety Code, to amend and repeal Section 138.7 of the Labor Code, and to amend Sections 5848.5, 10752, 14009.5, 14046.7, 14105.436, 14105.45, 14105.456, 14105.86, 14131.10, 14132.56, 14154, 14301.1, and 14592 of, and to amend, repeal, and add Section 14593 of, the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.~~

## LEGISLATIVE COUNSEL'S DIGEST

AB 1605, as amended, Committee on Budget. ~~Budget Act of 2016.~~  
*Health.*

*(1) Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that took effect January 1, 2014. Among other things, PPACA requires each state, by January 1, 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. Existing state law establishes the California Health Benefit Exchange (the Exchange) within state government for the purpose of facilitating the enrollment of qualified individuals and qualified small employers in qualified health plans, and specifies the powers and duties of the board governing the Exchange. Existing law authorizes the board of the Exchange to adopt any necessary regulations as emergency regulations until January 1, 2017. Existing law allows the emergency regulations adopted by the board to remain in effect for 3 years, as specified.*

*This bill would authorize the board to adopt any necessary regulations to implement the eligibility, enrollment, and appeals processes for the individual and small business exchanges, changes to the small business exchange, or any act in effect that amends the provisions governing the Exchange that is operative on or before December 31, 2016, as emergency regulations. The bill would instead allow the emergency regulations adopted by the board to remain in effect for 5 years, as specified.*

*(2) Existing law creates the State Department of Public Health and vests it with duties, powers, functions, jurisdiction, and responsibilities with regard to the advancement of public health.*

*This bill would require the department, subject to an appropriation for this purpose in the Budget Act of 2016, to award funding to local health departments, local government agencies, or on a competitive basis to community-based organizations, regional opioid prevention coalitions, or both, to support or establish programs that provide Naloxone to first responders and to at-risk opioid users through programs that serve at-risk drug users, including, but not limited to, syringe exchange and disposal programs, homeless programs, and substance use disorder treatment providers.*

*(3) Existing law establishes the Long-Term Care Quality Assurance Fund in the State Treasury and requires all revenues received by the*

*State Department of Health Care Services categorized by the department as long-term care quality assurance fees, including specified fees on certain intermediate care facilities and skilled nursing facilities, as specified, to be deposited into the fund. Existing law requires the moneys in the fund to be available, upon appropriation by the Legislature, for expenditure by the department to provide supplemental Medi-Cal reimbursement for intermediate care facility services, as specified, and to enhance federal financial participation in the Medi-Cal program or to provide additional reimbursement to, and support facility quality improvement efforts in, licensed skilled nursing facilities.*

*This bill would continuously appropriate the moneys in the fund to the department, thereby making an appropriation.*

*(4) Existing law requires the State Public Health Officer, to the extent that state and federal funds are appropriated, to establish and administer a program to provide drug treatments to persons infected with human immunodeficiency virus (HIV). Existing law establishes the AIDS Drug Assistance Rebate Fund, which is continuously appropriated and contains specified rebates from drug manufacturers, and authorizes expenditures from the fund for purposes of this program.*

*This bill would require the State Public Health Officer, to the extent that state and federal funds are appropriated, to establish and administer a program to provide drug treatments to persons who are HIV-negative who have been prescribed preexposure prophylaxis included on the ADAP formulary for the prevention of HIV infection. The bill would authorize the State Public Health Officer, to the extent allowable under federal law and as appropriated in the annual Budget Act, to expend funding from the AIDS Drug Assistance Program Rebate Fund for this HIV infection prevention program to cover the costs of prescribed ADAP formulary medications for the prevention of HIV infection and other specified costs.*

*Existing law authorizes the State Department of Public Health to subsidize certain cost-sharing requirements for persons otherwise eligible for the AIDS Drug Assistance Program (ADAP) with existing non-ADAP drug coverage by paying for prescription drugs included on the ADAP formulary within the existing ADAP operational structure, as specified. Under existing law, if the State Public Health Officer determines that it would result in a cost savings to the state, the department is authorized to subsidize, using available federal funds and moneys from the AIDS Drug Assistance Program Rebate Fund,*

*costs associated with a health care service plan or health insurance policy and premiums to purchase or maintain health insurance coverage.*

*The bill would delete the requirement that the State Public Health Officer determine that there would be a cost savings to the state before the department may subsidize the above-described costs with available federal funds and moneys from the AIDS Drug Assistance Program Rebate Fund.*

*Existing law requires the department to establish and administer a payment schedule to determine the payment obligation of a person receiving drugs under the program, as specified. Existing law limits the payment obligation to the lessor of 2 times the person's annual state income tax liability, less health insurance premium payments, or the cost of the drugs.*

*This bill would delete the above-described payment obligation. The bill would also make conforming changes.*

*(5) Existing law establishes the State Department of Public Health for purposes of, among other things, providing or facilitating access to certain health services and programs. Existing law requires the department to administer certain programs related to hepatitis B and hepatitis C, as specified.*

*This bill would require the State Department of Public Health to, among other things, purchase and distribute certain hepatitis B and hepatitis C materials to local entities for purposes of testing and vaccination, as specified. The bill would further require the department to facilitate related training and other technical assistance relating to syringe exchanges. The bill would authorize the department to issue grants for these purposes. The bill would make these provisions subject to funding provided for these purposes.*

*(6) Existing law authorizes any postsecondary higher educational institution with a medical center to establish diagnostic and treatment centers for Alzheimer's disease, and requires the State Department of Public Health to administer grants to the postsecondary higher educational institutions that establish a center pursuant to these provisions.*

*This bill would require the department to allocate funds to those centers, from funds appropriated to the department in the Budget Act of 2016, to be used for specified purposes, including to conduct targeted outreach to health professionals and to provide low-cost, accessible detection and diagnosis tools, as specified.*

(7) Existing law establishes the Office of Health Information Integrity, headed by the Director of the Office of Health Information Integrity, within the California Health and Human Services Agency and requires the office to assume statewide leadership, coordination, policy formulation, direction, and oversight responsibilities for implementation of the federal Health Insurance Portability and Accountability Act (HIPAA). Existing law requires the director to establish an advisory committee to obtain information on statewide HIPAA implementation activities, which is required to meet at a minimum 2 times per year. Existing law requires the Department of Finance to develop and annually publish prior to August 1 guidelines for state entities, as defined, to obtain additional HIPAA funding, and to report to the Legislature quarterly on HIPAA allocations, redirections, and expenditures, categorized by state entity and by project.

This bill would revise those provisions to reflect the office's duties regarding ongoing compliance with HIPAA. The bill would delete the provisions pertaining to the advisory committee and the Department of Finance requirements to publish guidelines and report to the Legislature.

(8) Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Existing law prohibits a person or public or private entity who is not a party to a claim for workers' compensation benefits from obtaining individually identifiable information, as defined, that is obtained or maintained by the Division of Workers' Compensation of the Department of Industrial Relations on that claim, except as specified. Existing law authorizes, until January 1, 2017, the use by the State Department of Health Care Services of individually identifiable information to seek recovery of Medi-Cal costs.

This bill would delete that January 1, 2017, date of repeal and thereby extend the operation of this authority of the State Department of Health Care Services indefinitely.

(9) The California Health Facilities Financing Authority Act authorizes the California Health Facilities Financing Authority (authority) to make loans from the continuously appropriated California Health Facilities Financing Authority Fund to participating health institutions for financing or refinancing the acquisition, construction, or remodeling of health facilities.

*Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Oversight and Accountability Commission (commission) to oversee the administration of various parts of the Mental Health Services Act. The act provides that it may be amended by the Legislature by a 2/3 vote of each house as long as the amendment is consistent with and furthers the intent of the act, and that the Legislature may also clarify procedures and terms of the act by majority vote.*

*Existing law establishes the Investment in Mental Health Wellness Act of 2013. Existing law provides that funds appropriated by the Legislature to the authority for the purposes of the act be made available to selected counties or counties acting jointly, except as otherwise provided, and used to increase capacity for client assistance and services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. Existing law requires the authority to develop and to consider specified selection criteria for awarding grants, as prescribed. Existing law provides that funds appropriated by the Legislature to the commission for the purposes of the act be allocated to selected counties, counties acting jointly, or city mental health departments, as determined by the commission through a selection process, for triage personnel to provide intensive case management and linkage to services for individuals with mental health disorders. Existing law requires the commission to consider specified selection criteria for awarding grants. Existing law prohibits funds awarded by the authority or commission from being used to supplant existing financial and resource commitments of the grantee.*

*This bill would extend the application of these provisions for purposes of providing mental health services to children and youth 21 years of age and under, subject to appropriation in the 2016 Budget Act. The bill would similarly provide that funds appropriated by the Legislature to the authority for these purposes be made available to selected counties or counties acting jointly, and used to increase capacity for client assistance and crisis services, as specified. The bill would require the authority to develop and consider specified selection criteria for awarding grants, as prescribed. The bill would similarly provide that funds appropriated by the Legislature to the commission for these purposes be allocated to selected counties, counties acting jointly, or city mental health departments, as determined by the commission*

*through a selection process, for specified purposes. The bill would require the commission to consider specified selection criteria for awarding grants. The bill would require the authority and the commission to provide prescribed reports to the fiscal and policy committees of the Legislature by January 1, 2018, and annually thereafter.*

*(10) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions.*

*Existing federal law requires the state to seek adjustment or recovery from an individual's estate for specified medical assistance, including nursing facility services, home and community-based services, and related hospital and prescription drug services, if the individual was 55 years of age or older when he or she received the medical assistance. Existing federal law allows the state, at its own option, to seek recovery for any items or services covered under the state's Medicaid plan.*

*Existing state law, with certain exceptions, requires the State Department of Health Care Services to claim against the estate of a decedent, or against any recipient of the property of that decedent by distribution or survival, an amount equal to the payments for Medi-Cal services received or the value of the property received by any recipient from the decedent by distribution or survival, whichever is less. Existing law provides for certain exemptions that restrict the department from filing a claim against a decedent's property, including if there is a surviving spouse during his or her lifetime. Existing law requires the department, however, to make a claim upon the death of the surviving spouse, as prescribed. Existing law requires the department to waive its claim, in whole or in part, if it determines that enforcement of the claim would result in a substantial hardship, as specified. Existing law, which has been held invalid by existing case law, provides that the exemptions shall only apply to the proportionate share of the decedent's estate or property that passes to those recipients, by survival or distribution, who qualify for the exemptions.*

*This bill would instead require the department to make these claims only in specified circumstances for those health care services that the state is required to recover under federal law and would define health care services for these purposes. The bill would limit any claims against the estate of a decedent to only the real and personal property or other*

*assets in the individual's probate estate that the state is required to seek recovery from under federal law. The bill would delete the proportionate share provision and would delete the requirement that the department make a claim upon the death of the surviving spouse. The bill would prohibit the department from filing a claim against a decedent's property if there is a surviving registered domestic partner. The bill would require the department, subject to federal approval, to waive its claim when the estate subject to recovery is a homestead of modest value, as defined. The bill would limit the amount of interest that is entitled to accrue on a voluntary postdeath lien, as specified. The bill would also require the department to provide a current or former member, or his or her authorized representative, upon request, with a copy of the amount of Medi-Cal expenses that would be recoverable under these provisions, as specified. The bill would apply the changes made by these provisions only to individuals who die on or after January 1, 2017.*

*(11) Existing law requires the State Department of Health Care Services to establish and administer, until July 1, 2021, the Medi-Cal Electronic Health Records Incentive Program, for the purposes of providing federal incentive payments to Medi-Cal providers for the implementation and use of electronic records systems. Existing law generally prohibits General Fund moneys from being used for this purpose, except that no more than \$200,000 from the General Fund may be used annually for state administrative costs associated with implementing these provisions.*

*This bill would increase the amount of General Fund moneys that may be used annually for state administrative costs to no more than \$425,000.*

*(12) Existing law provides for a schedule of benefits under the Medi-Cal program, which includes Early and Periodic Screening, Diagnosis, and Treatment for any individual under 21 years of age, consistent with the requirements of federal law. Under existing law, to the extent required by the federal government and effective no sooner than required by the federal government, behavioral health treatment (BHT), as defined, is a covered service for individuals under 21 years of age, as specified.*

*This bill would authorize the department, commencing on the effective date of the bill to March 31, 2017, inclusive, to make available to specified individuals whom the department identifies as no longer eligible for Medi-Cal solely due to the transition of BHT coverage*

*pursuant to the above provisions, contracted services to assist the individuals with health insurance enrollment, without regard to whether federal funds are available for the contracted services.*

*(13) Existing law prohibits the reimbursement to Medi-Cal pharmacy providers for legend and nonlegend drugs, as defined, from exceeding the lowest of either the estimated acquisition cost of the drug plus a professional fee for dispensing or the pharmacy's usual and customary charge, as defined. The professional fee is statutorily set at \$7.25 per dispensed prescription and at \$8 for legend drugs dispensed to a beneficiary residing in a skilled nursing facility or intermediate care facility, as defined. If the State Department of Health Care Services determines that a change in the dispensing fee is necessary, existing law requires the department to establish the new dispensing fee through the state budget process and prohibits any adjustments to the dispensing fee from exceeding a specified amount. Existing law requires the estimated acquisition cost of the drug to be equal to the lowest of the average wholesale price minus 17%, the average acquisition cost, the federal upper limit, or the maximum allowable ingredient cost.*

*This bill, commencing April 1, 2017, would make inoperative the prescribed amounts for the professional fees and, instead, require the department to implement a new professional dispensing fee or fees, as defined, established by the department consistent with a specified provision of federal law. The bill would require the department to adjust the professional dispensing fee through the state budget process if necessary to comply with federal Medicaid requirements. The bill would revise the definition of "federal upper limit."*

*(14) Existing law provides for a schedule of benefits under the Medi-Cal program, which includes specified outpatient services, including acupuncture to the extent federal matching funds are provided for acupuncture, subject to utilization controls. Notwithstanding this provision, existing law excludes certain optional Medi-Cal benefits, including, among others, acupuncture services, from coverage under the Medi-Cal program.*

*This bill, commencing July 1, 2016, would restore acupuncture services as a covered benefit under the Medi-Cal program.*

*(15) Existing law requires counties to determine Medi-Cal eligibility, and requires each county to meet specified performance standards in administering Medi-Cal eligibility. Existing law requires the department to establish and maintain a plan, known as the County Administrative Cost Control Plan, for the purpose of effectively controlling costs related*

*to the county administration of the determination of eligibility for benefits under the Medi-Cal program within the amounts annually appropriated for that administration. Under existing law, the Legislature finds and declares that linking appropriate funding for county Medi-Cal administrative operations, including annual cost-of-doing-business adjustments, with performance standards will give counties the incentive to meet the performance standards and enable them to continue to do the work they do on behalf of the state. Existing law further provides that it is the intent of the Legislature to provide appropriate funding to the counties for the effective administration of the Medi-Cal program, and that it is the intent of the Legislature to not appropriate money for a cost-of-doing-business adjustment for specified fiscal years.*

*This bill would additionally provide that it is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2016–17 fiscal year.*

*(16) Under existing law, the Emergency Medical Air Transportation Act, a penalty of \$4 is imposed upon every conviction for a violation of the Vehicle Code, or a local ordinance adopted pursuant to the Vehicle Code, other than a parking offense. Existing law requires the county or the court that imposed the fine to transfer the moneys collected pursuant to this act to the Emergency Medical Air Transportation Act Fund. Existing law requires the State Department of Health Care Services to administer the Emergency Medical Air Transportation Act Fund and to use the moneys in the fund, upon appropriation by the Legislature, to, among other things, offset the state portion of the Medi-Cal reimbursement rate for emergency medical air transportation services and augment emergency medical air transportation reimbursement payments made through the Medi-Cal program. Under existing law, the assessment of these penalties will terminate on January 1, 2018, and any moneys unexpended and unencumbered in the Emergency Medical Air Transportation Act Fund on June 30, 2019, will transfer to the General Fund. Existing law requires the department, by March 1, 2017, and in coordination with the Department of Finance, to develop a funding plan that ensures adequate reimbursement to emergency medical air transportation providers following the termination of the penalty assessments.*

*This bill would instead require the department, by March 1, 2017, and in coordination with the Department of Finance, to notify the Legislature of the fiscal impact on the Medi-Cal program resulting from, and the planned reimbursement methodology for emergency*

medical air transportation services after, the termination of the penalty assessments.

(17) Existing federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals so that they may continue living in the community. Federal law authorizes states to implement the PACE program as a Medicaid state option. Existing law authorizes the department to enter into contracts with up to 15 PACE organizations, defined as public or private nonprofit organizations, to implement the PACE program, as specified. Existing law, on and after April 1, 2015, requires the department to establish capitation rates paid to each PACE organization at no less than 95% of the fee-for-service equivalent cost, including the department's cost of administration, that the department estimates would be payable for all services covered under the PACE organization contract if all those services were to be furnished to Medi-Cal beneficiaries under the fee-for-service program.

This bill would require the department to develop and pay capitation rates to contracted PACE organizations, for rates implemented no earlier than January 1, 2017, in accordance with criteria specific to those organizations, based on, among other things, standardized rate methodologies for similar populations, adjustments for geographic location, and the level of care being provided. The bill would delete the requirement that contracts for implementation of the PACE program be entered into with organizations that are nonprofit.

This bill also would authorize the department, to the extent federal financial participation is available, to seek increased federal regulatory flexibility to modernize the PACE program, as specified. Implementation of the new capitation rate methodology would be contingent on receipt of federal approval and the availability of federal financial participation. The bill would provide alternative rate capitation methodologies, depending upon whether or not the Coordinated Care Initiative is operative, as specified.

(18) This bill would also delete or make inoperative various obsolete provisions of law and make various other technical changes.

(19) This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.

~~This bill would express the intent of the Legislature to enact statutory changes relating to the Budget Act of 2016.~~

Vote: majority. Appropriation: ~~no~~-yes. Fiscal committee: ~~no~~ yes. State-mandated local program: no.

*The people of the State of California do enact as follows:*

1     SECTION 1. Section 100504 of the Government Code is  
2     amended to read:

3     100504. (a) The board may do the following:

4     (1) With respect to individual coverage made available in the  
5     Exchange, collect premiums and assist in the administration of  
6     subsidies.

7     (2) Enter into contracts.

8     (3) Sue and be sued.

9     (4) Receive and accept gifts, grants, or donations of moneys  
10    from any agency of the United States, any agency of the state, and  
11    any municipality, county, or other political subdivision of the state.

12    (5) Receive and accept gifts, grants, or donations from  
13    individuals, associations, private foundations, and corporations,  
14    in compliance with the conflict of interest provisions to be adopted  
15    by the board at a public meeting.

16    (6) Adopt rules and regulations, as necessary. Until January 1,  
17    2017, any necessary rules and regulations may be adopted as  
18    emergency regulations in accordance with the Administrative  
19    Procedure Act (Chapter 3.5 (commencing with Section 11340) of  
20    Part 1 of Division 3 of Title 2). *Until January 1, 2019, any*  
21    *necessary rules and regulations to implement the eligibility,*  
22    *enrollment, and appeals processes for the individual and small*  
23    *business exchanges, changes to the small business exchange, or*  
24    *any act in effect that amends this title that is operative on or before*  
25    *December 31, 2016, may be adopted as emergency regulations in*  
26    *accordance with the Administrative Procedure Act (Chapter 3.5*  
27    *(commencing with Section 11340) of Part 1 of Division 3 of Title*  
28    *2). The adoption of—these—regulations emergency regulations*  
29    *pursuant to this section shall be deemed to be an emergency and*  
30    *necessary for the immediate preservation of the public peace, health*  
31    *and safety, or general welfare. Notwithstanding Chapter 3.5*  
32    *(commencing with Section 11340) of Part 1 of Division 3 of Title*  
33    *2, including subdivisions (e) and (h) of Section 11346.1, any*  
34    *emergency regulation adopted pursuant to this section shall be*  
35    *repealed by operation of law unless the adoption, amendment, or*  
36    *repeal of the regulation is promulgated by the board pursuant to*  
37    *Chapter 3.5 (commencing with Section 11340) of Part 1 of Division*  
38    *3 of Title 2 of the Government Code within three five years of the*

1 initial adoption of the emergency regulation. Notwithstanding  
2 subdivision (h) of Section 11346.1, until January 1, 2020, the  
3 Office of Administrative Law may approve more than two  
4 readoptions of an emergency regulation adopted pursuant to this  
5 section. The amendments made to this paragraph by the act adding  
6 this sentence shall apply to any emergency regulation adopted  
7 pursuant to this section prior to the effective date of the Budget  
8 Act of 2015.

9 (7) Collaborate with the State Department of Health Care  
10 Services and the Managed Risk Medical Insurance Board, to the  
11 extent possible, to allow an individual the option to remain enrolled  
12 with his or her carrier and provider network in the event the  
13 individual experiences a loss of eligibility of premium tax credits  
14 and becomes eligible for the Medi-Cal program or the Healthy  
15 Families Program, or loses eligibility for the Medi-Cal program  
16 or the Healthy Families Program and becomes eligible for premium  
17 tax credits through the Exchange.

18 (8) Share information with relevant state departments, consistent  
19 with the confidentiality provisions in Section 1411 of the federal  
20 act, necessary for the administration of the Exchange.

21 (9) Require carriers participating in the Exchange to make  
22 available to the Exchange and regularly update an electronic  
23 directory of contracting health care providers so that individuals  
24 seeking coverage through the Exchange can search by health care  
25 provider name to determine which health plans in the Exchange  
26 include that health care provider in their network. The board may  
27 also require a carrier to provide regularly updated information to  
28 the Exchange as to whether a health care provider is accepting  
29 new patients for a particular health plan. The Exchange may  
30 provide an integrated and uniform consumer directory of health  
31 care providers indicating which carriers the providers contract with  
32 and whether the providers are currently accepting new patients.  
33 The Exchange may also establish methods by which health care  
34 providers may transmit relevant information directly to the  
35 Exchange, rather than through a carrier.

36 (10) Make available supplemental coverage for enrollees of the  
37 Exchange to the extent permitted by the federal act, provided that  
38 no General Fund money is used to pay the cost of that coverage.  
39 Any supplemental coverage offered in the Exchange shall be

1 subject to the charge imposed under subdivision (n) of Section  
2 100503.

3 (b) The Exchange shall only collect information from individuals  
4 or designees of individuals necessary to administer the Exchange  
5 and consistent with the federal act.

6 (c) (1) The board shall have the authority to standardize  
7 products to be offered through the Exchange. Any products  
8 standardized by the board pursuant to this subdivision shall be  
9 discussed by the board during at least one properly noticed board  
10 meeting prior to the board meeting at which the board adopts the  
11 standardized products to be offered through the Exchange.

12 (2) The adoption, amendment, or repeal of a regulation by the  
13 board to implement this subdivision is exempt from the rulemaking  
14 provisions of the Administrative Procedure Act (Chapter 3.5  
15 (commencing with Section 11340) of Part 1 of Division 3 of Title  
16 2).

17 *SEC. 2. Part 6.2 (commencing with Section 1179.80) is added*  
18 *to Division 1 of the Health and Safety Code, to read:*

19  
20 *PART 6.2. NALOXONE GRANT PROGRAM*  
21

22 *1179.80. (a) In order to reduce the rate of fatal overdose from*  
23 *opioid drugs including heroin and prescription opioids, the State*  
24 *Department of Public Health shall, subject to an appropriation*  
25 *for this purpose in the Budget Act of 2016, award funding to local*  
26 *health departments, local government agencies, or on a competitive*  
27 *basis to community-based organizations, regional opioid*  
28 *prevention coalitions, or both, to support or establish programs*  
29 *that provide Naloxone to first responders and to at-risk opioid*  
30 *users through programs that serve at-risk drug users, including,*  
31 *but not limited to, syringe exchange and disposal programs,*  
32 *homeless programs, and substance use disorder treatment*  
33 *providers.*

34 *(b) The department may award grants itself or enter into*  
35 *contracts to carry out the provisions of subdivision (a). The award*  
36 *of contracts and grants is exempt from Part 2 (commencing with*  
37 *Section 10100) of Division 2 of the Public Contract Code and is*  
38 *exempt from approval by the Department of General Services prior*  
39 *to their execution.*

1     (c) *Not more than 10 percent of the funds appropriated shall*  
2 *be available to the department for its administrative costs in*  
3 *implementing this section. If deemed necessary by the department,*  
4 *the department may allocate funds to other state departments to*  
5 *assist in the implementation of subdivision (a).*

6     SEC. 3. *Section 1324.9 of the Health and Safety Code is*  
7 *amended to read:*

8     1324.9. (a) The Long-Term Care Quality Assurance Fund is  
9 hereby created in the State Treasury. ~~Moneys in the fund shall be~~  
10 ~~available, upon appropriation by the Legislature, for expenditure~~  
11 ~~by~~ *Notwithstanding Section 13340 of the Government Code,*  
12 *moneys in the fund shall be continuously appropriated, without*  
13 *regard to fiscal year, to the State Department of Health Care*  
14 *Services for the purposes of this article and Article 7.6*  
15 *(commencing with Section 1324.20). Notwithstanding Section*  
16 *16305.7 of the Government Code, the fund shall contain all interest*  
17 *and dividends earned on moneys in the fund.*

18     (b) Notwithstanding any other law, beginning August 1, 2013,  
19 all revenues received by the State Department of Health Care  
20 Services categorized by the State Department of Health Care  
21 Services as long-term care quality assurance fees shall be deposited  
22 into the Long-Term Care Quality Assurance Fund. Revenue that  
23 shall be deposited into this fund shall include quality assurance  
24 fees imposed pursuant to this article and quality assurance fees  
25 imposed pursuant to Article 7.6 (commencing with Section  
26 1324.20).

27     (c) Notwithstanding any other law, the Controller may use the  
28 funds in the Long-Term Care Quality Assurance Fund for cashflow  
29 loans to the General Fund as provided in Sections 16310 and 16381  
30 of the Government Code.

31     SEC. 4. *Section 120955 of the Health and Safety Code is*  
32 *amended to read:*

33     120955. (a) (1) To the extent that state and federal funds are  
34 appropriated in the annual Budget Act for these purposes, the  
35 director shall establish and may administer a program to provide  
36 drug treatments to persons infected with human immunodeficiency  
37 virus (HIV), the etiologic agent of acquired immunodeficiency  
38 syndrome ~~(AIDS)~~. *(AIDS), and to persons who are HIV-negative*  
39 *who have been prescribed preexposure prophylaxis included on*  
40 *the ADAP formulary for the prevention of HIV infection. To the*

1 *extent allowable under federal law, and as appropriated in the*  
2 *annual Budget Act, the director may expend funding from the AIDS*  
3 *Drug Assistance Program Rebate Fund for this HIV infection*  
4 *prevention program to cover the costs of prescribed ADAP*  
5 *formulary medications for the prevention of HIV infection and*  
6 *related medical copays, coinsurance, and deductibles. If the*  
7 director makes a formal determination that, in any fiscal year,  
8 funds appropriated for the program will be insufficient to provide  
9 all of those drug treatments to existing eligible persons for the  
10 fiscal year and that a suspension of the implementation of the  
11 program is necessary, the director may suspend eligibility  
12 determinations and enrollment in the program for the period of  
13 time necessary to meet the needs of existing eligible persons in  
14 the program.

15 (2) The director, in consultation with the AIDS Drug Assistance  
16 Program Medical Advisory Committee, shall develop, maintain,  
17 and update as necessary a list of drugs to be provided under this  
18 program. The list shall be exempt from the requirements of the  
19 Administrative Procedure Act (Chapter 3.5 (commencing with  
20 Section 11340), Chapter 4 (commencing with Section 11370), and  
21 Chapter 5 (commencing with Section 11500) of Part 1 of Division  
22 3 of Title 2 of the Government Code), and shall not be subject to  
23 the review and approval of the Office of Administrative Law.

24 (b) The director may grant funds to a county public health  
25 department through standard agreements to administer this program  
26 in that county. To maximize the recipients' access to drugs covered  
27 by this program, the director shall urge the county health  
28 department in counties granted these funds to decentralize  
29 distribution of the drugs to the recipients.

30 (c) The director shall establish a rate structure for reimbursement  
31 for the cost of each drug included in the program. Rates shall not  
32 be less than the actual cost of the drug. However, the director may  
33 purchase a listed drug directly from the manufacturer and negotiate  
34 the most favorable bulk price for that drug.

35 (d) Manufacturers of the drugs on the list shall pay the  
36 department a rebate equal to the rebate that would be applicable  
37 to the drug under Section 1927(c) of the federal Social Security  
38 Act (42 U.S.C. Sec. 1396r-8(c)) plus an additional rebate to be  
39 negotiated by each manufacturer with the department, except that  
40 no rebates shall be paid to the department under this section on

1 drugs for which the department has received a rebate under Section  
2 1927(c) of the federal Social Security Act (42 U.S.C. Sec.  
3 1396r-8(c)) or that have been purchased on behalf of county health  
4 departments or other eligible entities at discount prices made  
5 available under Section 256b of Title 42 of the United States Code.

6 (e) The department shall submit an invoice, not less than two  
7 times per year, to each manufacturer for the amount of the rebate  
8 required by subdivision (d).

9 (f) Drugs may be removed from the list for failure to pay the  
10 rebate required by subdivision (d), unless the department  
11 determines that removal of the drug from the list would cause  
12 substantial medical hardship to beneficiaries.

13 (g) The department may adopt emergency regulations to  
14 implement amendments to this chapter made during the 1997–98  
15 Regular Session, in accordance with the Administrative Procedure  
16 Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of  
17 Division 3 of Title 2 of the Government Code). The initial adoption  
18 of emergency regulations shall be deemed to be an emergency and  
19 considered by the Office of Administrative Law as necessary for  
20 the immediate preservation of the public peace, health and safety,  
21 or general welfare. Emergency regulations adopted pursuant to  
22 this section shall remain in effect for no more than 180 days.

23 (h) Reimbursement under this chapter shall not be made for any  
24 drugs that are available to the recipient under any other private,  
25 state, or federal programs, or under any other contractual or legal  
26 entitlements, except that the director may authorize an exemption  
27 from this subdivision where exemption would represent a cost  
28 savings to the state.

29 (i) The department may also subsidize certain cost-sharing  
30 requirements for persons otherwise eligible for the AIDS Drug  
31 Assistance Program (ADAP) with existing non-ADAP drug  
32 coverage by paying for prescription drugs included on the ADAP  
33 formulary within the existing ADAP operational structure up to,  
34 but not exceeding, the amount of that cost-sharing obligation. This  
35 cost sharing may only be applied in circumstances in which the  
36 other payer recognizes the ADAP payment as counting toward the  
37 individual's cost-sharing obligation. ~~If the director determines that~~  
38 ~~it would result in a cost savings to the state, the~~ *The* department  
39 may subsidize, using available federal funds and moneys from the  
40 AIDS Drug Assistance Program Rebate Fund, costs associated

1 with a health care service plan or health insurance policy, including  
2 medical copayments and deductibles for outpatient care, and  
3 premiums to purchase or maintain health insurance coverage.

4 *SEC. 5. Section 120960 of the Health and Safety Code is*  
5 *amended to read:*

6 120960. (a) The department shall establish uniform standards  
7 of financial eligibility for the drugs under the program established  
8 under this chapter.

9 (b) Nothing in the financial eligibility standards shall prohibit  
10 drugs to an otherwise eligible person whose modified adjusted  
11 gross income does not exceed 500 percent of the federal poverty  
12 level per year based on family size and household income.  
13 However, the director may authorize drugs for persons with  
14 incomes higher than 500 percent of the federal poverty level per  
15 year based on family size and household income if the estimated  
16 cost of those drugs in one year is expected to exceed 20 percent  
17 of the person's modified adjusted gross income.

18 ~~(c) The department shall establish and may administer a payment~~  
19 ~~schedule to determine the payment obligation of a person receiving~~  
20 ~~drugs. No person shall be obligated for payment whose modified~~  
21 ~~adjusted gross income is less than four times the federal poverty~~  
22 ~~level based on family size and household income. The payment~~  
23 ~~obligation shall be the lesser of the following:~~

24 ~~(1) Two times the person's annual state income tax liability,~~  
25 ~~less funds expended by the person for health insurance premiums.~~

26 ~~(2) The cost of drugs.~~

27 ~~(d) Persons who have been determined to have a payment~~  
28 ~~obligation pursuant to subdivision (c) shall be advised by the~~  
29 ~~department of their right to request a reconsideration of that~~  
30 ~~determination to the department. Written notice of the right to~~  
31 ~~request a reconsideration shall be provided to the person at the~~  
32 ~~time that notification is given that he or she is subject to a payment~~  
33 ~~obligation. The payment determination shall be reconsidered if~~  
34 ~~one or more of the following apply:~~

35 ~~(1) The determination was based on an incorrect calculation~~  
36 ~~made pursuant to subdivision (b).~~

37 ~~(2) There has been a substantial change in income since the~~  
38 ~~previous eligibility determination that has resulted in a current~~  
39 ~~income that is inadequate to meet the calculated payment~~  
40 ~~obligation.~~

1 ~~(3) Unavoidable family or medical expenses that reduce the~~  
2 ~~disposable income and that result in current income that is~~  
3 ~~inadequate to meet the payment obligation.~~

4 ~~(4) Any other situation that imposes undue financial hardship~~  
5 ~~on the person and would restrict his or her ability to meet the~~  
6 ~~payment obligation.~~

7 ~~(e) The department may exempt a person, who has been~~  
8 ~~determined to have a payment obligation pursuant to subdivision~~  
9 ~~(e), from the obligation if both of the following criteria are~~  
10 ~~satisfied:~~

11 ~~(1) One or more of the circumstances specified in subdivision~~  
12 ~~(d) exist.~~

13 ~~(2) The department has determined that the payment obligation~~  
14 ~~will impose an undue financial hardship on the person.~~

15 ~~(f) If a person requests reconsideration of the payment obligation~~  
16 ~~determination, the person shall not be obligated to make any~~  
17 ~~payment until the department has completed the reconsideration~~  
18 ~~request pursuant to subdivision (d). If the department denies the~~  
19 ~~exemption, the person shall be obligated to make payments for~~  
20 ~~drugs received while the reconsideration request is pending.~~

21 ~~(g)~~  
22 ~~(c) A county public health department administering this~~  
23 ~~program pursuant to an agreement with the director pursuant to~~  
24 ~~subdivision (b) of Section 120955 shall use no more than 5 percent~~  
25 ~~of total payments it collects pursuant to this section to cover any~~  
26 ~~administrative costs related to eligibility determinations, reporting~~  
27 ~~requirements, and the collection of payments.~~

28 ~~(h)~~  
29 ~~(d) A county public health department administering this~~  
30 ~~program pursuant to subdivision (b) of Section 120955 shall~~  
31 ~~provide all drugs added to the program pursuant to subdivision (a)~~  
32 ~~of Section 120955 within 60 days of the action of the director,~~  
33 ~~subject to the repayment obligations specified in subdivision (d)~~  
34 ~~of Section 120965: director.~~

35 ~~(i)~~  
36 ~~(e) For purposes of this section, the following terms shall have~~  
37 ~~the following meanings:~~

38 ~~(1) "Family size" has the meaning given to that term in Section~~  
39 ~~36B(d)(1) of the Internal Revenue Code of 1986, and shall include~~  
40 ~~same or opposite sex married couples, registered domestic partners,~~

1 and any tax dependents, as defined by Section 152 of the Internal  
2 Revenue Code of 1986, of either spouse or registered domestic  
3 partner.

4 (2) “Federal poverty level” refers to the poverty guidelines  
5 updated periodically in the Federal Register by the United States  
6 Department of Health and Human Services under the authority of  
7 Section 9902(2) of Title 42 of the United States Code.

8 (3) “Household income” means the sum of the applicant’s or  
9 recipient’s modified adjusted gross income, plus the modified  
10 adjusted gross income of the applicant’s or recipient’s spouse or  
11 registered domestic partner, and the modified adjusted gross  
12 incomes of all other individuals for whom the applicant or  
13 recipient, or the applicant’s or recipient’s spouse or registered  
14 domestic partner, is allowed a federal income tax deduction for  
15 the taxable year.

16 (4) “Internal Revenue Code of 1986” means Title 26 of the  
17 United States Code, including all amendments enacted to that code.

18 (5) “Modified adjusted gross income” has the meaning given  
19 to that term in Section 36B(d)(2)(B) of the Internal Revenue Code  
20 of 1986.

21 *SEC. 6. Section 120965 of the Health and Safety Code is*  
22 *repealed.*

23 ~~120965. (a) Effective March 15, 1991, a person determined~~  
24 ~~eligible for benefits under this chapter shall be subject to the~~  
25 ~~payment obligation specified in subdivision (c) of Section 120960.~~

26 ~~(b) Persons who are receiving benefits under a HIV drug~~  
27 ~~treatment subsidy program administered by the department prior~~  
28 ~~to March 15, 1991, shall not be subject to the payment obligation~~  
29 ~~specified in subdivision (c) of Section 120960.~~

30 ~~(c) Notwithstanding subdivision (b), if any person is disenrolled~~  
31 ~~from eligibility in a HIV drug treatment subsidy program~~  
32 ~~administered by the department for any reason after March 15,~~  
33 ~~1991, the subsequent enrollment of that person for benefits under~~  
34 ~~this chapter shall be in accordance with the payment obligation~~  
35 ~~specified in subdivision (c) of Section 120960.~~

36 ~~(d) Notwithstanding subdivision (b), if a drug is added pursuant~~  
37 ~~to subdivision (a) of Section 120955, any person determined~~  
38 ~~eligible for benefits under this chapter, regardless of the date of~~  
39 ~~enrollment, shall be subject to the payment obligation specified in~~  
40 ~~subdivision (c) of Section 120960 for the added drug. The payment~~

1 ~~obligation for any other drug shall be determined in accordance~~  
2 ~~with subdivision (b).~~

3 SEC. 7. Part 7.5 (commencing with Section 122450) is added  
4 to Division 105 of the Health and Safety Code, to read:

5  
6 PART 7.5. COMMUNICABLE DISEASE TESTING AND  
7 PREVENTION  
8

9 122450. (a) Of the funds appropriated in the 2016 Budget Act  
10 for this purpose, the State Department of Public Health shall do  
11 all of the following:

12 (1) Purchase and distribute hepatitis B vaccine and related  
13 materials to local health jurisdictions and community-based  
14 organizations to test and vaccinate high-risk adults.

15 (2) Purchase hepatitis C test kits and related materials to  
16 distribute to local health jurisdictions and community-based testing  
17 programs.

18 (3) Train nonmedical personnel to perform HCV and HIV testing  
19 waived under the federal Clinical Laboratory Improvement  
20 Amendments of 1998 (CLIA) (42 U.S.C. Sec. 263a) in local health  
21 jurisdictions and community-based settings.

22 (4) Provide technical assistance to local governments and  
23 community-based organizations to increase the number of syringe  
24 exchange and disposal programs throughout California and the  
25 number of jurisdictions in which syringe exchange and disposal  
26 programs are authorized.

27 (b) The State Department of Public Health may issue grants for  
28 the materials and activities provided for in subdivision (a).

29 SEC. 8. Section 125281 is added to the Health and Safety Code,  
30 to read:

31 125281. From funds appropriated to the department in the  
32 Budget Act of 2016 for these purposes, the department shall  
33 allocate funds to the diagnostic and treatment centers for  
34 Alzheimer's disease established pursuant to Section 125280 to be  
35 used for all of the following purposes:

36 (a) To determine the standard of care in early and accurate  
37 diagnosis drawing on peer-reviewed evidence, best practices,  
38 Medicare and Medicaid policy and reimbursement, and experience  
39 working with patients seeking services at a center.

1     (b) *To conduct targeted outreach to health professionals through*  
2     *medical school instruction, hospital grant rounds, continuing*  
3     *education, community education, and free online resources.*

4     (c) *To provide low-cost, accessible detection and diagnosis*  
5     *tools that the center shall make available via open source portals*  
6     *of the postsecondary higher educational institution that established*  
7     *the center. Furthermore, the department shall post these tools on*  
8     *its Internet Web site to serve as a resource for the state.*

9     (d) *To endorse and disseminate low-cost, accessible detection*  
10    *and diagnosis tools for broad use by health professionals*  
11    *practicing in a variety of settings.*

12    (e) *To address unique health disparities that exist within diverse*  
13    *populations, with special focus and attention on reaching African*  
14    *Americans, Latinos, and women.*

15    (f) *To evaluate the educational effectiveness and measure the*  
16    *impact of these efforts, including pretests and posttests for health*  
17    *professionals, metrics, and documented practice change.*

18    SEC. 9. *Section 130301 of the Health and Safety Code is*  
19    *amended to read:*

20    130301. The Legislature finds and declares the following:

21    (a) The federal Health Insurance Portability and Accountability  
22    Act (Public Law 104-191), known as HIPAA, was enacted on  
23    August 21, 1996.

24    (b) HIPAA extends health coverage benefits to workers after  
25    they terminate or change employment by allowing the worker to  
26    participate in existing group coverage plans, thereby avoiding the  
27    additional expense associated with obtaining individual coverage  
28    as well as the potential loss of coverage because of a preexisting  
29    health condition.

30    (c) Administrative simplification is a key feature of HIPAA,  
31    requiring standard national identifiers for providers, employers,  
32    and health plans and the development of uniform standards for the  
33    coding and transmission of claims and health care information.  
34    Administration simplification is intended to promote the use of  
35    information technology, thereby reducing costs and increasing  
36    efficiency in the health care industry.

37    (d) HIPAA also contains ~~new~~ standards for safeguarding the  
38    privacy and security of health information. Therefore, the  
39    development of policies for safeguarding the privacy and security  
40    of health records is a fundamental and indispensable part of HIPAA

1 implementation that must accompany or precede the expansion or  
2 standardization of technology for recording or transmitting health  
3 information.

4 (e) The federal Department of Health and Human Services has  
5 published, and continues to publish, rules pertaining to the  
6 implementation of HIPAA. Following a 60-day congressional  
7 concurrence period, health providers and insurers have 24 months  
8 in which to implement these rules.

9 (f) These federal rules directly apply to state and county  
10 departments that provide health coverage, health care, mental  
11 health services, and alcohol and drug treatment programs. Other  
12 state and county departments are subject to these rules to the extent  
13 they use or exchange information with the departments to which  
14 the federal rules directly apply.

15 (g) In view of the substantial changes that HIPAA will require  
16 in the practices of both private and public health entities and their  
17 business associates, the ability of California government to  
18 continue the delivery of vital health services will depend upon the  
19 implementation-~~of~~ *of, and compliance with*, HIPAA in a manner  
20 that is coordinated among state departments as well as our partners  
21 in county government and the private health sector.

22 (h) The implementation of HIPAA shall be accomplished as  
23 required by federal law and regulations and shall be a priority for  
24 state departments.

25 *SEC. 10. Section 130303 of the Health and Safety Code is*  
26 *amended to read:*

27 130303. The office shall assume statewide leadership,  
28 coordination, policy formulation, direction, and oversight  
29 responsibilities for HIPAA-~~implementation~~ *implementation and*  
30 *compliance*. The office shall exercise full authority relative to state  
31 entities to establish policy, provide direction to state entities,  
32 monitor progress, and report on implementation-~~efforts~~ *and*  
33 *compliance activities*.

34 *SEC. 11. Section 130305 of the Health and Safety Code is*  
35 *amended to read:*

36 130305. The office shall be staffed, at a minimum, with the  
37 following personnel:

38 (a) Legal counsel to perform activities that may include, but are  
39 not limited to, determining the application of federal law pertaining  
40 to HIPAA.

- 1 (b) Staff with expertise in the rules promulgated by HIPAA.  
2 ~~(e) Staff to oversee the development of training curricula and~~  
3 ~~tools and to modify the curricula and tools as required by the state's~~  
4 ~~ongoing HIPAA compliance effort.~~  
5 ~~(d) Information technology staff.~~  
6 ~~(e)~~  
7 (c) Staff, as necessary, to coordinate and monitor the progress  
8 made by all state entities in HIPAA—~~implementation.~~  
9 *implementation and compliance.*  
10 ~~(f) Administrative staff, as necessary.~~  
11 SEC. 12. *Section 130306 of the Health and Safety Code is*  
12 *amended to read:*  
13 130306. ~~(a)~~ The office shall perform the following functions:  
14 ~~(1)~~  
15 (a) Standardizing the HIPAA implementation process used in  
16 all state entities, which includes the following:  
17 ~~(A)~~  
18 (1) ~~Developing a master plan and~~ an overall state strategy for  
19 HIPAA implementation *and compliance* that includes timeframes  
20 within which specified activities will be completed.  
21 ~~(B)~~  
22 (2) Specifying tools, such as protocols for assessment and  
23 reporting, and any other tools as determined by the director for  
24 ~~HIPAA implementation.~~ *implementation and compliance.*  
25 ~~(C)~~  
26 (3) Developing uniform policies on privacy, security, and other  
27 matters related to HIPAA that shall be adopted and implemented  
28 by all state entities. In developing these policies, the office shall  
29 consult with representatives from the private sector, state  
30 government, and other public entities affected by HIPAA.  
31 ~~(D)~~  
32 (4) Providing an ongoing evaluation of HIPAA implementation  
33 *and compliance* in California and refining the plans, tools, and  
34 policies as required to effect implementation.  
35 ~~(E)~~  
36 (5) Developing standards for the office to use in determining  
37 the extent of HIPAA compliance.  
38 ~~(2)~~  
39 (b) Representing the State of California in HIPAA discussions  
40 with the federal Department of Health and Human Services and

1 at the Workgroup for Electronic Data Interchange and other  
2 national and regional groups developing standards for HIPAA  
3 implementation, including those authorized by the federal  
4 Department of Health and Human Services to receive comments  
5 related to HIPAA. ~~In preparing comments for submission to these~~  
6 ~~entities, the office shall work in coordination with private and~~  
7 ~~public entities to which the comments relate.~~ The office may review  
8 and approve all comments related to HIPAA that state entities or  
9 representatives from the University of California, to the extent  
10 authorized by its Regents, propose for submission to the federal  
11 Department of Health and Human Services or any other body or  
12 organization.

13 ~~(3)~~

14 (c) Monitoring the HIPAA implementation *and compliance*  
15 activities of state entities and requiring these entities to report on  
16 their ~~implementation~~ activities at times specified by the director  
17 using a format prescribed by the director. The office shall seek the  
18 cooperation of counties in monitoring HIPAA implementation *and*  
19 *compliance* in programs that are administered by county  
20 government.

21 ~~(4)~~

22 (d) Providing state entities with technical assistance as the  
23 director deems necessary and appropriate to advance the state's  
24 implementation *and compliance* of HIPAA as required by the  
25 schedule adopted by the federal Department of Health and Human  
26 Services. This assistance shall also include sharing information  
27 obtained by the office relating to HIPAA.

28 ~~(5) Providing the Department of Finance with recommendations~~  
29 ~~on HIPAA implementation expenditures, including proposals~~  
30 ~~submitted by state entities and a recommendation on the amount~~  
31 ~~to be appropriated for allocation by the Department of Finance to~~  
32 ~~entities implementing HIPAA.~~

33 ~~(6) Conducting a periodic assessment at least once every three~~  
34 ~~years to determine whether staff positions established in the office~~  
35 ~~and in other state entities to perform HIPAA compliance activities~~  
36 ~~continue to be necessary or whether additional staff positions are~~  
37 ~~required to complete these activities.~~

38 ~~(7) Reviewing and approving contracts relating to HIPAA to~~  
39 ~~which a state entity is a party prior to the contract's effective date.~~

40 ~~(8)~~

1 (e) Reviewing and approving all HIPAA legislation *and*  
2 *regulations* proposed by state entities, other than state control  
3 agencies, prior to the proposal's review by any other entity and  
4 reviewing all analyses and positions, other than those prepared by  
5 state control agencies, on HIPAA related legislation being  
6 considered by either Congress or the Legislature.

7 ~~(9)~~

8 (f) Ensuring state departments claim federal funding for those  
9 activities that qualify under federal funding criteria.

10 ~~(10) Establishing a~~

11 (g) *Maintaining an Internet* Web site that is accessible to the  
12 public to provide information in a consistent and accessible format  
13 concerning state HIPAA implementation activities, timeframes  
14 for completing those activities, HIPAA implementation  
15 requirements that have been met, and the promulgation of federal  
16 regulations pertaining to HIPAA implementation. ~~The office shall~~  
17 ~~update this Web site quarterly.~~

18 ~~(b) In performing these functions, the office shall coordinate its~~  
19 ~~activities with the State Office of Privacy Protection.~~

20 *SEC. 13. Section 130307 of the Health and Safety Code is*  
21 *repealed.*

22 ~~130307. The director shall establish an advisory committee to~~  
23 ~~obtain information on statewide HIPAA implementation activities,~~  
24 ~~which shall meet at a minimum of two times per year. It is the~~  
25 ~~intent of the Legislature that the committee's membership include~~  
26 ~~representatives from county government, from consumers, and~~  
27 ~~from a broad range of provider groups, such as physicians and~~  
28 ~~surgeons, clinics, hospitals, pharmaceutical companies, health care~~  
29 ~~service plans, disability insurers, long-term care facilities, facilities~~  
30 ~~for the developmentally disabled, and mental health providers.~~  
31 ~~The director shall invite key stakeholders from the federal~~  
32 ~~government, the Judicial Council, health care advocates, nonprofit~~  
33 ~~health care organizations, public health systems, and the private~~  
34 ~~sector to provide information to the committee.~~

35 *SEC. 14. Section 130309 of the Health and Safety Code is*  
36 *amended to read:*

37 130309. (a) All state entities subject to HIPAA shall complete  
38 an assessment, in a form specified by the office, ~~prior to January~~  
39 ~~1, 2002,~~ *office* to determine the impact of HIPAA on their  
40 operations. ~~The office shall report the statewide results of the~~

1 ~~assessment to the appropriate policy and fiscal committees of the~~  
2 ~~Legislature on or before May 15, 2002.~~

3 (b) ~~Other~~ All state entities shall cooperate with the office to  
4 determine whether they are subject to HIPAA, including, but not  
5 limited to, providing a completed assessment as prescribed by the  
6 office.

7 *SEC. 15. Section 130310 of the Health and Safety Code is*  
8 *amended to read:*

9 130310. All state entities shall cooperate with the efforts of  
10 the office to monitor HIPAA implementation *and compliance*  
11 activities and to obtain information on those activities.

12 *SEC. 16. Section 130312 of the Health and Safety Code is*  
13 *repealed.*

14 ~~130312.—(a) The Department of Finance shall provide a~~  
15 ~~complete accounting of HIPAA expenditures made by all state~~  
16 ~~entities.~~

17 (b) ~~The Department of Finance, in consultation with the office,~~  
18 ~~shall develop and annually publish prior to August 1, guidelines~~  
19 ~~for state entities to obtain additional HIPAA funding. All funding~~  
20 ~~requests from state entities for HIPAA implementation, including,~~  
21 ~~but not limited to, requests for appropriations through the Budget~~  
22 ~~Act or other legislation and requests for allocation of lump-sum~~  
23 ~~funds from the Department of Finance, shall be reviewed and~~  
24 ~~approved by the office prior to being submitted to the Department~~  
25 ~~of Finance. Funding requests pertaining to information technology~~  
26 ~~activities shall also be reviewed and approved by the Department~~  
27 ~~of Information Technology.~~

28 (c) ~~The Department of Finance shall notify the office and the~~  
29 ~~Chairperson of the Senate Committee on Budget and Fiscal Review~~  
30 ~~and the Chairperson of the Assembly Budget Committee of each~~  
31 ~~allocation it approves within 10 working days of the approval. The~~  
32 ~~Department of Finance shall also report to the Legislature quarterly~~  
33 ~~on HIPAA allocations, redirections, and expenditures, categorized~~  
34 ~~by state entity and by project.~~

35 *SEC. 17. Section 130313 of the Health and Safety Code is*  
36 *amended to read:*

37 130313. To the extent that funds are appropriated in the annual  
38 Budget Act, the office shall perform the following functions in  
39 order to comply with HIPAA requirements:

1 (a) ~~The establishment and ongoing~~ *Ongoing* support of  
2 departmental HIPAA project management offices.

3 (b) The development, revision, and issuance of HIPAA  
4 compliance policies.

5 (c) Modifications of programs in accordance with any revised  
6 policies.

7 (d) Staff training on HIPAA compliance policies and programs.

8 (e) Coordination and communication with other affected entities.

9 ~~(f) Modifications to, or replacement of, information technology~~  
10 ~~systems.~~

11 *(f) Evaluate, monitor, and report on HIPAA implementation*  
12 *and compliance activities of state entities affected by HIPAA.*

13 (g) Consultation with appropriate stakeholders.

14 *SEC. 18. Section 138.7 of the Labor Code, as amended by*  
15 *Section 80 of Chapter 46 of the Statutes of 2012, is amended to*  
16 *read:*

17 138.7. (a) Except as expressly permitted in subdivision (b), a  
18 person or public or private entity not a party to a claim for workers'  
19 compensation benefits ~~may~~ *shall* not obtain individually  
20 identifiable information obtained or maintained by the division on  
21 that claim. For purposes of this section, "individually identifiable  
22 information" means any data concerning an injury or claim that is  
23 linked to a uniquely identifiable employee, employer, claims  
24 administrator, or any other person or entity.

25 (b) (1) (A) The administrative director, or a statistical agent  
26 designated by the administrative director, may use individually  
27 identifiable information for purposes of creating and maintaining  
28 the workers' compensation information system as specified in  
29 Section 138.6.

30 (B) The administrative director may publish the identity of  
31 claims administrators in the annual report disclosing the compliance  
32 rates of claims administrators pursuant to subdivision (d) of Section  
33 138.6.

34 (2) (A) The State Department of Public Health may use  
35 individually identifiable information for purposes of establishing  
36 and maintaining a program on occupational health and occupational  
37 disease prevention as specified in Section 105175 of the Health  
38 and Safety Code.

39 (B) (i) The State Department of Health Care Services may use  
40 individually identifiable information for purposes of seeking

1 recovery of Medi-Cal costs incurred by the state for treatment  
2 provided to injured workers that should have been incurred by  
3 employers and insurance carriers pursuant to Article 3.5  
4 (commencing with Section 14124.70) of Chapter 7 of Part 3 of  
5 Division 9 of the Welfare and Institutions Code.

6 (ii) The Department of Industrial Relations shall furnish  
7 individually identifiable information to the State Department of  
8 Health Care Services, and the State Department of Health Care  
9 Services may furnish the information to its designated agent,  
10 provided that the individually identifiable information shall not  
11 be disclosed for use other than the purposes described in clause  
12 (i). The administrative director may adopt regulations solely for  
13 the purpose of governing access by the State Department of Health  
14 Care Services or its designated agents to the individually  
15 identifiable information as defined in subdivision (a).

16 (3) (A) Individually identifiable information may be used by  
17 the Division of Workers' Compensation and the Division of  
18 Occupational Safety and Health as necessary to carry out their  
19 duties. The administrative director shall adopt regulations  
20 governing the access to the information described in this  
21 subdivision by these divisions. Any regulations adopted pursuant  
22 to this subdivision shall set forth the specific uses for which this  
23 information may be obtained.

24 (B) Individually identifiable information maintained in the  
25 workers' compensation information system and the Division of  
26 Workers' Compensation may be used by researchers employed by  
27 or under contract to the Commission on Health and Safety and  
28 Workers' Compensation as necessary to carry out the commission's  
29 research. The administrative director shall adopt regulations  
30 governing the access to the information described in this  
31 subdivision by commission researchers. These regulations shall  
32 set forth the specific uses for which this information may be  
33 obtained and include provisions guaranteeing the confidentiality  
34 of individually identifiable information. Individually identifiable  
35 information obtained under this subdivision shall not be disclosed  
36 to commission members. No individually identifiable information  
37 obtained by researchers under contract to the commission pursuant  
38 to this subparagraph may be disclosed to any other person or entity,  
39 public or private, for a use other than that research project for  
40 which the information was obtained. Within a reasonable period

1 of time after the research for which the information was obtained  
2 has been completed, the data collected shall be modified in a  
3 manner so that the subjects cannot be identified, directly or through  
4 identifiers linked to the subjects.

5 (4) The administrative director shall adopt regulations allowing  
6 reasonable access to individually identifiable information by other  
7 persons or public or private entities for the purpose of bona fide  
8 statistical research. This research shall not divulge individually  
9 identifiable information concerning a particular employee,  
10 employer, claims administrator, or any other person or entity. The  
11 regulations adopted pursuant to this paragraph shall include  
12 provisions guaranteeing the confidentiality of individually  
13 identifiable information. Within a reasonable period of time after  
14 the research for which the information was obtained has been  
15 completed, the data collected shall be modified in a manner so that  
16 the subjects cannot be identified, directly or through identifiers  
17 linked to the subjects.

18 (5) (A) This section shall not operate to exempt from disclosure  
19 any information that is considered to be a public record pursuant  
20 to the California Public Records Act (Chapter 3.5 (commencing  
21 with Section 6250) of Division 7 of Title 1 of the Government  
22 Code) contained in an individual's file once an application for  
23 adjudication has been filed pursuant to Section 5501.5.

24 (B) ~~However, individually~~ *Individually* identifiable information  
25 shall not be provided to any person or public or private entity who  
26 is not a party to the claim unless that person identifies himself or  
27 herself or that public or private entity identifies itself and states  
28 the reason for making the request. The administrative director may  
29 require the person or public or private entity making the request  
30 to produce information to verify that the name and address of the  
31 requester is valid and correct. If the purpose of the request is related  
32 to preemployment screening, the administrative director shall  
33 notify the person about whom the information is requested that  
34 the information was provided and shall include the following in  
35 12-point type:

36  
37 "IT MAY BE A VIOLATION OF FEDERAL AND STATE  
38 LAW TO DISCRIMINATE AGAINST A JOB APPLICANT  
39 BECAUSE THE APPLICANT HAS FILED A CLAIM FOR  
40 WORKERS' COMPENSATION BENEFITS."

1  
2 (C) Any residence address is confidential and shall not be  
3 disclosed to any person or public or private entity except to a party  
4 to the claim, a law enforcement agency, an office of a district  
5 attorney, any person for a journalistic purpose, or other  
6 governmental agency.

7 (D) ~~Nothing in this~~ This paragraph shall be construed to *does*  
8 *not* prohibit the use of individually identifiable information for  
9 purposes of identifying bona fide lien claimants.

10 (c) Except as provided in subdivision (b), individually  
11 identifiable information obtained by the division is privileged and  
12 is not subject to subpoena in a civil proceeding unless, after  
13 reasonable notice to the division and a hearing, a court determines  
14 that the public interest and the intent of this section will not be  
15 jeopardized by disclosure of the information. This section shall  
16 not operate to restrict access to information by any law enforcement  
17 agency or district attorney's office or to limit admissibility of that  
18 information in a criminal proceeding.

19 (d) ~~It shall be~~ *is* unlawful for any person who has received  
20 individually identifiable information from the division pursuant  
21 to this section to provide that information to any person who is  
22 not entitled to it under this section.

23 (e) ~~This section shall remain in effect only until January 1, 2017,~~  
24 ~~and as of that date is repealed, unless a later enacted statute, that~~  
25 ~~is enacted before January 1, 2017, deletes or extends that date.~~

26 *SEC. 19. Section 138.7 of the Labor Code, as amended by*  
27 *Section 81 of Chapter 46 of the Statutes of 2012, is repealed.*

28 ~~138.7. (a) Except as expressly permitted in subdivision (b), a~~  
29 ~~person or public or private entity not a party to a claim for workers'~~  
30 ~~compensation benefits may not obtain individually identifiable~~  
31 ~~information obtained or maintained by the division on that claim.~~  
32 ~~For purposes of this section, "individually identifiable information"~~  
33 ~~means any data concerning an injury or claim that is linked to a~~  
34 ~~uniquely identifiable employee, employer, claims administrator,~~  
35 ~~or any other person or entity.~~

36 ~~(b) (1) (A) The administrative director, or a statistical agent~~  
37 ~~designated by the administrative director, may use individually~~  
38 ~~identifiable information for purposes of creating and maintaining~~  
39 ~~the workers' compensation information system as specified in~~  
40 ~~Section 138.6.~~

~~(B) The administrative director may publish the identity of claims administrators in the annual report disclosing the compliance rates of claims administrators pursuant to subdivision (d) of Section 138.6.~~

~~(2) The State Department of Public Health may use individually identifiable information for purposes of establishing and maintaining a program on occupational health and occupational disease prevention as specified in Section 105175 of the Health and Safety Code.~~

~~(3) (A) Individually identifiable information may be used by the Division of Workers' Compensation and the Division of Occupational Safety and Health as necessary to carry out their duties. The administrative director shall adopt regulations governing the access to the information described in this subdivision by these divisions. Any regulations adopted pursuant to this subdivision shall set forth the specific uses for which this information may be obtained.~~

~~(B) Individually identifiable information maintained in the workers' compensation information system and the Division of Workers' Compensation may be used by researchers employed by or under contract to the Commission on Health and Safety and Workers' Compensation as necessary to carry out the commission's research. The administrative director shall adopt regulations governing the access to the information described in this subdivision by commission researchers. These regulations shall set forth the specific uses for which this information may be obtained and include provisions guaranteeing the confidentiality of individually identifiable information. Individually identifiable information obtained under this subdivision shall not be disclosed to commission members. No individually identifiable information obtained by researchers under contract to the commission pursuant to this subparagraph may be disclosed to any other person or entity, public or private, for a use other than that research project for which the information was obtained. Within a reasonable period of time after the research for which the information was obtained has been completed, the data collected shall be modified in a manner so that the subjects cannot be identified, directly or through identifiers linked to the subjects.~~

~~(4) The administrative director shall adopt regulations allowing reasonable access to individually identifiable information by other~~

1 persons or public or private entities for the purpose of bona fide  
2 statistical research. This research shall not divulge individually  
3 identifiable information concerning a particular employee,  
4 employer, claims administrator, or any other person or entity. The  
5 regulations adopted pursuant to this paragraph shall include  
6 provisions guaranteeing the confidentiality of individually  
7 identifiable information. Within a reasonable period of time after  
8 the research for which the information was obtained has been  
9 completed, the data collected shall be modified in a manner so that  
10 the subjects cannot be identified, directly or through identifiers  
11 linked to the subjects.

12 (5) (A) This section shall not operate to exempt from disclosure  
13 any information that is considered to be a public record pursuant  
14 to the California Public Records Act (Chapter 3.5 (commencing  
15 with Section 6250) of Division 7 of Title 1 of the Government  
16 Code) contained in an individual's file once an application for  
17 adjudication has been filed pursuant to Section 5501.5.

18 (B) However, individually identifiable information shall not be  
19 provided to any person or public or private entity who is not a  
20 party to the claim unless that person identifies himself or herself  
21 or that public or private entity identifies itself and states the reason  
22 for making the request. The administrative director may require  
23 the person or public or private entity making the request to produce  
24 information to verify that the name and address of the requester  
25 is valid and correct. If the purpose of the request is related to  
26 preemployment screening, the administrative director shall notify  
27 the person about whom the information is requested that the  
28 information was provided and shall include the following in  
29 12-point type:

30  
31 “IT MAY BE A VIOLATION OF FEDERAL AND STATE  
32 LAW TO DISCRIMINATE AGAINST A JOB APPLICANT  
33 BECAUSE THE APPLICANT HAS FILED A CLAIM FOR  
34 WORKERS’ COMPENSATION BENEFITS.”

35  
36 (C) Any residence address is confidential and shall not be  
37 disclosed to any person or public or private entity except to a party  
38 to the claim, a law enforcement agency, an office of a district  
39 attorney, any person for a journalistic purpose, or other  
40 governmental agency.

1     ~~(D) Nothing in this paragraph shall be construed to prohibit the~~  
2     ~~use of individually identifiable information for purposes of~~  
3     ~~identifying bona fide lien claimants.~~

4     ~~(e) Except as provided in subdivision (b), individually~~  
5     ~~identifiable information obtained by the division is privileged and~~  
6     ~~is not subject to subpoena in a civil proceeding unless, after~~  
7     ~~reasonable notice to the division and a hearing, a court determines~~  
8     ~~that the public interest and the intent of this section will not be~~  
9     ~~jeopardized by disclosure of the information. This section shall~~  
10    ~~not operate to restrict access to information by any law enforcement~~  
11    ~~agency or district attorney's office or to limit admissibility of that~~  
12    ~~information in a criminal proceeding.~~

13    ~~(d) It shall be unlawful for any person who has received~~  
14    ~~individually identifiable information from the division pursuant~~  
15    ~~to this section to provide that information to any person who is~~  
16    ~~not entitled to it under this section.~~

17    ~~(e) This section shall become operative on January 1, 2017.~~

18    ~~SEC. 20. Section 5848.5 of the Welfare and Institutions Code~~  
19    ~~is amended to read:~~

20    5848.5. (a) The Legislature finds and declares all of the  
21    following:

22    (1) California has realigned public community mental health  
23    services to counties and it is imperative that sufficient  
24    community-based resources be available to meet the mental health  
25    needs of eligible individuals.

26    (2) Increasing access to effective outpatient and crisis  
27    stabilization services provides an opportunity to reduce costs  
28    associated with expensive inpatient and emergency room care and  
29    to better meet the needs of individuals with mental health disorders  
30    in the least restrictive manner possible.

31    (3) Almost one-fifth of people with mental health disorders visit  
32    a hospital emergency room at least once per year. If an adequate  
33    array of crisis services is not available, it leaves an individual with  
34    little choice but to access an emergency room for assistance and,  
35    potentially, an unnecessary inpatient hospitalization.

36    (4) Recent reports have called attention to a continuing problem  
37    of inappropriate and unnecessary utilization of hospital emergency  
38    rooms in California due to limited community-based services for  
39    individuals in psychological distress and acute psychiatric crisis.  
40    Hospitals report that 70 percent of people taken to emergency

1 rooms for psychiatric evaluation can be stabilized and transferred  
2 to a less intensive level of crisis care. Law enforcement personnel  
3 report that their personnel need to stay with people in the  
4 emergency room waiting area until a placement is found, and that  
5 less intensive levels of care tend not to be available.

6 (5) Comprehensive public and private partnerships at both local  
7 and regional levels, including across physical health services,  
8 mental health, substance use disorder, law enforcement, social  
9 services, and related supports, are necessary to develop and  
10 maintain high quality, patient-centered, and cost-effective care for  
11 individuals with mental health disorders that facilitates their  
12 recovery and leads towards wellness.

13 (6) The recovery of individuals with mental health disorders is  
14 important for all levels of government, business, and the local  
15 community.

16 (b) This section shall be known, and may be cited, as the  
17 Investment in Mental Health Wellness Act of 2013. The objectives  
18 of this section are to do all of the following:

19 (1) Expand access to early intervention and treatment services  
20 to improve the client experience, achieve recovery and wellness,  
21 and reduce costs.

22 (2) Expand the continuum of services to address crisis  
23 intervention, crisis stabilization, and crisis residential treatment  
24 needs that are wellness, resiliency, and recovery oriented.

25 (3) Add at least 25 mobile crisis support teams and at least 2,000  
26 crisis stabilization and crisis residential treatment beds to bolster  
27 capacity at the local level to improve access to mental health crisis  
28 services and address unmet mental health care needs.

29 (4) Add at least 600 triage personnel to provide intensive case  
30 management and linkage to services for individuals with mental  
31 health care disorders at various points of access, such as at  
32 designated community-based service points, homeless shelters,  
33 and clinics.

34 (5) Reduce unnecessary hospitalizations and inpatient days by  
35 appropriately utilizing community-based services and improving  
36 access to timely assistance.

37 (6) Reduce recidivism and mitigate unnecessary expenditures  
38 of local law enforcement.

39 (7) Provide local communities with increased financial resources  
40 to leverage additional public and private funding sources to achieve

1 improved networks of care for individuals with mental health  
2 disorders.

3 *(8) Provide a complete continuum of crisis services for children*  
4 *and youth 21 years of age and under regardless of where they live*  
5 *in the state. The funds included in the 2016 Budget Act for the*  
6 *purpose of developing the continuum of mental health crisis*  
7 *services for children and youth 21 years of age and under shall*  
8 *be for the following objectives:*

9 *(A) Provide a continuum of crisis services for children and*  
10 *youth 21 years of age and under regardless of where they live in*  
11 *the state.*

12 *(B) Provide for early intervention and treatment services to*  
13 *improve the client experience, achieve recovery and wellness, and*  
14 *reduce costs.*

15 *(C) Expand the continuum of community-based services to*  
16 *address crisis intervention, crisis stabilization, and crisis*  
17 *residential treatment needs that are wellness-, resiliency-, and*  
18 *recovery-oriented.*

19 *(D) Add at least 200 mobile crisis support teams.*

20 *(E) Add at least 120 crisis stabilization services and beds and*  
21 *crisis residential treatment beds to increase capacity at the local*  
22 *level to improve access to mental health crisis services and address*  
23 *unmet mental health care needs.*

24 *(F) Add triage personnel to provide intensive case management*  
25 *and linkage to services for individuals with mental health care*  
26 *disorders at various points of access, such as at designated*  
27 *community-based service points, homeless shelters, schools, and*  
28 *clinics.*

29 *(G) Expand family respite care to help families and sustain*  
30 *caregiver health and well-being.*

31 *(H) Expand family supportive training and related services*  
32 *designed to help families participate in the planning process,*  
33 *access services, and navigate programs.*

34 *(I) Reduce unnecessary hospitalizations and inpatient days by*  
35 *appropriately utilizing community-based services.*

36 *(J) Reduce recidivism and mitigate unnecessary expenditures*  
37 *of local law enforcement.*

38 *(K) Provide local communities with increased financial*  
39 *resources to leverage additional public and private funding sources*

1 *to achieve improved networks of care for children and youth 21*  
2 *years of age and under with mental health disorders.*

3 (c) Through appropriations provided in the annual Budget Act  
4 for this purpose, it is the intent of the Legislature to authorize the  
5 California Health Facilities Financing Authority, hereafter referred  
6 to as the authority, and the Mental Health Services Oversight and  
7 Accountability Commission, hereafter referred to as the  
8 commission, to administer competitive selection processes as  
9 provided in this section for capital capacity and program expansion  
10 to increase capacity for mobile crisis support, crisis intervention,  
11 crisis stabilization services, crisis residential treatment, and  
12 specified personnel resources.

13 (d) Funds appropriated by the Legislature to the authority for  
14 purposes of this section shall be made available to selected  
15 counties, or counties acting jointly. The authority may, at its  
16 discretion, also give consideration to private nonprofit corporations  
17 and public agencies in an area or region of the state if a county, or  
18 counties acting jointly, affirmatively supports this designation and  
19 collaboration in lieu of a county government directly receiving  
20 grant funds.

21 (1) Grant awards made by the authority shall be used to expand  
22 local resources for the development, capital, equipment acquisition,  
23 and applicable program startup or expansion costs to increase  
24 capacity for client assistance and services in the following areas:

25 (A) Crisis intervention, as authorized by Sections 14021.4,  
26 14680, and 14684.

27 (B) Crisis stabilization, as authorized by Sections 14021.4,  
28 14680, and 14684.

29 (C) Crisis residential treatment, as authorized by Sections  
30 14021.4, 14680, and 14684.

31 (D) Rehabilitative mental health services, as authorized by  
32 Sections 14021.4, 14680, and 14684.

33 (E) Mobile crisis support teams, including personnel and  
34 equipment, such as the purchase of vehicles.

35 (2) The authority shall develop selection criteria to expand local  
36 resources, including those described in paragraph (1), and processes  
37 for awarding grants after consulting with representatives and  
38 interested stakeholders from the mental health community,  
39 including, but not limited to, the County Behavioral Health  
40 Directors Association of California, service providers, consumer

1 organizations, and other appropriate interests, such as health care  
2 providers and law enforcement, as determined by the authority.  
3 The authority shall ensure that grants result in cost-effective  
4 expansion of the number of community-based crisis resources in  
5 regions and communities selected for funding. The authority shall  
6 also take into account at least the following criteria and factors  
7 when selecting recipients of grants and determining the amount  
8 of grant awards:

9 (A) Description of need, including, at a minimum, a  
10 comprehensive description of the project, community need,  
11 population to be served, linkage with other public systems of health  
12 and mental health care, linkage with local law enforcement, social  
13 services, and related assistance, as applicable, and a description  
14 of the request for funding.

15 (B) Ability to serve the target population, which includes  
16 individuals eligible for Medi-Cal and individuals eligible for county  
17 health and mental health services.

18 (C) Geographic areas or regions of the state to be eligible for  
19 grant awards, which may include rural, suburban, and urban areas,  
20 and may include use of the five regional designations utilized by  
21 the County Behavioral Health Directors Association of California.

22 (D) Level of community engagement and commitment to project  
23 completion.

24 (E) Financial support that, in addition to a grant that may be  
25 awarded by the authority, will be sufficient to complete and operate  
26 the project for which the grant from the authority is awarded.

27 (F) Ability to provide additional funding support to the project,  
28 including public or private funding, federal tax credits and grants,  
29 foundation support, and other collaborative efforts.

30 (G) Memorandum of understanding among project partners, if  
31 applicable.

32 (H) Information regarding the legal status of the collaborating  
33 partners, if applicable.

34 (I) Ability to measure key outcomes, including improved access  
35 to services, health and mental health outcomes, and cost benefit  
36 of the project.

37 (3) The authority shall determine maximum grants awards,  
38 which shall take into consideration the number of projects awarded  
39 to the grantee, as described in paragraph (1), and shall reflect  
40 reasonable costs for the project and geographic region. The

1 authority may allocate a grant in increments contingent upon the  
2 phases of a project.

3 (4) Funds awarded by the authority pursuant to this section may  
4 be used to supplement, but not to supplant, existing financial and  
5 resource commitments of the grantee or any other member of a  
6 collaborative effort that has been awarded a grant.

7 (5) All projects that are awarded grants by the authority shall  
8 be completed within a reasonable period of time, to be determined  
9 by the authority. Funds shall not be released by the authority until  
10 the applicant demonstrates project readiness to the authority's  
11 satisfaction. If the authority determines that a grant recipient has  
12 failed to complete the project under the terms specified in awarding  
13 the grant, the authority may require remedies, including the return  
14 of all or a portion of the grant.

15 (6) A grantee that receives a grant from the authority under this  
16 section shall commit to using that capital capacity and program  
17 expansion project, such as the mobile crisis team, crisis  
18 stabilization unit, or crisis residential treatment program, for the  
19 duration of the expected life of the project.

20 (7) The authority may consult with a technical assistance entity,  
21 as described in paragraph (5) of subdivision (a) of Section 4061,  
22 for purposes of implementing this section.

23 (8) The authority may adopt emergency regulations relating to  
24 the grants for the capital capacity and program expansion projects  
25 described in this section, including emergency regulations that  
26 define eligible costs and determine minimum and maximum grant  
27 amounts.

28 (9) The authority shall provide reports to the fiscal and policy  
29 committees of the Legislature on or before May 1, 2014, and on  
30 or before May 1, 2015, on the progress of implementation, that  
31 include, but are not limited to, the following:

32 (A) A description of each project awarded funding.

33 (B) The amount of each grant issued.

34 (C) A description of other sources of funding for each project.

35 (D) The total amount of grants issued.

36 (E) A description of project operation and implementation,  
37 including who is being served.

38 (10) A recipient of a grant provided pursuant to paragraph (1)  
39 shall adhere to all applicable laws relating to scope of practice,  
40 licensure, certification, staffing, and building codes.

1     (e) *Of the funds specified in paragraph (8) of subdivision (b),*  
2     *it is the intent of the Legislature to authorize the authority and the*  
3     *commission to administer competitive selection processes as*  
4     *provided in this section for capital capacity and program expansion*  
5     *to increase capacity for mobile crisis support, crisis intervention,*  
6     *crisis stabilization services, crisis residential treatment, family*  
7     *respite care, family supportive training and related services, and*  
8     *triage personnel resources for children and youth 21 years of age*  
9     *and under.*

10    (f) *Funds appropriated by the Legislature to the authority to*  
11    *address crisis services for children and youth 21 years of age and*  
12    *under for the purposes of this section shall be made available to*  
13    *selected counties or counties acting jointly. The authority may, at*  
14    *its discretion, also give consideration to private nonprofit*  
15    *corporations and public agencies in an area or region of the state*  
16    *if a county, or counties acting jointly, affirmatively support this*  
17    *designation and collaboration in lieu of a county government*  
18    *directly receiving grant funds.*

19    (1) *Grant awards made by the authority shall be used to expand*  
20    *local resources for the development, capital, equipment acquisition,*  
21    *and applicable program startup or expansion costs to increase*  
22    *capacity for client assistance and crisis services for children and*  
23    *youth 21 years of age and under in the following areas:*

24    (A) *Crisis intervention, as authorized by Sections 14021.4,*  
25    *14680, and 14684.*

26    (B) *Crisis stabilization, as authorized by Sections 14021.4,*  
27    *14680, and 14684.*

28    (C) *Crisis residential treatment, as authorized by Sections*  
29    *14021.4, 14680, and 14684.*

30    (D) *Mobile crisis support teams, including the purchase of*  
31    *equipment and vehicles.*

32    (E) *Family respite care.*

33    (2) *The authority shall develop selection criteria to expand local*  
34    *resources, including those described in paragraph (1), and*  
35    *processes for awarding grants after consulting with representatives*  
36    *and interested stakeholders from the mental health community,*  
37    *including, but not limited to, county mental health directors, service*  
38    *providers, consumer organizations, and other appropriate interests,*  
39    *such as health care providers and law enforcement, as determined*  
40    *by the authority. The authority shall ensure that grants result in*

1 *cost-effective expansion of the number of community-based crisis*  
2 *resources in regions and communities selected for funding. The*  
3 *authority shall also take into account at least the following criteria*  
4 *and factors when selecting recipients of grants and determining*  
5 *the amount of grant awards:*

6 *(A) Description of need, including, at a minimum, a*  
7 *comprehensive description of the project, community need,*  
8 *population to be served, linkage with other public systems of health*  
9 *and mental health care, linkage with local law enforcement, social*  
10 *services, and related assistance, as applicable, and a description*  
11 *of the request for funding.*

12 *(B) Ability to serve the target population, which includes*  
13 *individuals eligible for Medi-Cal and individuals eligible for county*  
14 *health and mental health services.*

15 *(C) Geographic areas or regions of the state to be eligible for*  
16 *grant awards, which may include rural, suburban, and urban*  
17 *areas, and may include use of the five regional designations utilized*  
18 *by the California Behavioral Health Directors Association.*

19 *(D) Level of community engagement and commitment to project*  
20 *completion.*

21 *(E) Financial support that, in addition to a grant that may be*  
22 *awarded by the authority, will be sufficient to complete and operate*  
23 *the project for which the grant from the authority is awarded.*

24 *(F) Ability to provide additional funding support to the project,*  
25 *including public or private funding, federal tax credits and grants,*  
26 *foundation support, and other collaborative efforts.*

27 *(G) Memorandum of understanding among project partners, if*  
28 *applicable.*

29 *(H) Information regarding the legal status of the collaborating*  
30 *partners, if applicable.*

31 *(I) Ability to measure key outcomes, including utilization of*  
32 *services, health and mental health outcomes, and cost benefit of*  
33 *the project.*

34 *(3) The authority shall determine maximum grant awards, which*  
35 *shall take into consideration the number of projects awarded to*  
36 *the grantee, as described in paragraph (1), and shall reflect*  
37 *reasonable costs for the project, geographic region, and target*  
38 *ages. The authority may allocate a grant in increments contingent*  
39 *upon the phases of a project.*

1     (4) *Funds awarded by the authority pursuant to this section*  
2     *may be used to supplement, but not to supplant, existing financial*  
3     *and resource commitments of the grantee or any other member of*  
4     *a collaborative effort that has been awarded a grant.*

5     (5) *All projects that are awarded grants by the authority shall*  
6     *be completed within a reasonable period of time, to be determined*  
7     *by the authority. Funds shall not be released by the authority until*  
8     *the applicant demonstrates project readiness to the authority's*  
9     *satisfaction. If the authority determines that a grant recipient has*  
10    *failed to complete the project under the terms specified in awarding*  
11    *the grant, the authority may require remedies, including the return*  
12    *of all, or a portion, of the grant.*

13    (6) *A grantee that receives a grant from the authority under this*  
14    *section shall commit to using that capital capacity and program*  
15    *expansion project, such as the mobile crisis team, crisis*  
16    *stabilization unit, family respite care, or crisis residential treatment*  
17    *program, for the duration of the expected life of the project.*

18    (7) *The authority may consult with a technical assistance entity,*  
19    *as described in paragraph (5) of subdivision (a) of Section 4061,*  
20    *for the purposes of implementing this section.*

21    (8) *The authority may adopt emergency regulations relating to*  
22    *the grants for the capital capacity and program expansion projects*  
23    *described in this section, including emergency regulations that*  
24    *define eligible costs and determine minimum and maximum grant*  
25    *amounts.*

26    (9) *The authority shall provide reports to the fiscal and policy*  
27    *committees of the Legislature on or before January 10, 2018, and*  
28    *annually thereafter, on the progress of implementation, that*  
29    *include, but are not limited to, the following:*

30    (A) *A description of each project awarded funding.*

31    (B) *The amount of each grant issued.*

32    (C) *A description of other sources of funding for each project.*

33    (D) *The total amount of grants issued.*

34    (E) *A description of project operation and implementation,*  
35    *including who is being served.*

36    (10) *A recipient of a grant provided pursuant to paragraph (1)*  
37    *shall adhere to all applicable laws relating to scope of practice,*  
38    *licensure, certification, staffing, and building codes.*

39    (e)

1 (g) Funds appropriated by the Legislature to the commission  
2 for purposes of this section shall be allocated for triage personnel  
3 to provide intensive case management and linkage to services for  
4 individuals with mental health disorders at various points of access.  
5 These funds shall be made available to selected counties, counties  
6 acting jointly, or city mental health departments, as determined  
7 by the commission through a selection process. It is the intent of  
8 the Legislature for these funds to be allocated in an efficient manner  
9 to encourage early intervention and receipt of needed services for  
10 individuals with mental health disorders, and to assist in navigating  
11 the local service sector to improve efficiencies and the delivery of  
12 services.

13 (1) Triage personnel may provide targeted case management  
14 services face to face, by telephone, or by telehealth with the  
15 individual in need of assistance or his or her significant support  
16 person, and may be provided anywhere in the community. These  
17 service activities may include, but are not limited to, the following:

18 (A) Communication, coordination, and referral.

19 (B) Monitoring service delivery to ensure the individual accesses  
20 and receives services.

21 (C) Monitoring the individual's progress.

22 (D) Providing placement service assistance and service plan  
23 development.

24 (2) The commission shall take into account at least the following  
25 criteria and factors when selecting recipients and determining the  
26 amount of grant awards for triage personnel as follows:

27 (A) Description of need, including potential gaps in local service  
28 connections.

29 (B) Description of funding request, including personnel and use  
30 of peer support.

31 (C) Description of how triage personnel will be used to facilitate  
32 linkage and access to services, including objectives and anticipated  
33 outcomes.

34 (D) Ability to obtain federal Medicaid reimbursement, when  
35 applicable.

36 (E) Ability to administer an effective service program and the  
37 degree to which local agencies and service providers will support  
38 and collaborate with the triage personnel effort.

39 (F) Geographic areas or regions of the state to be eligible for  
40 grant awards, which shall include rural, suburban, and urban areas,

1 and may include use of the five regional designations utilized by  
2 the County Behavioral Health Directors Association of California.

3 (3) The commission shall determine maximum grant awards,  
4 and shall take into consideration the level of need, population to  
5 be served, and related criteria, as described in paragraph (2), and  
6 shall reflect reasonable costs.

7 (4) Funds awarded by the commission for purposes of this  
8 section may be used to supplement, but not supplant, existing  
9 financial and resource commitments of the county, counties acting  
10 jointly, or city mental health department that received the grant.

11 (5) Notwithstanding any other law, a county, counties acting  
12 jointly, or city mental health department that receives an award of  
13 funds for the purpose of supporting triage personnel pursuant to  
14 this subdivision is not required to provide a matching contribution  
15 of local funds.

16 (6) Notwithstanding any other law, the commission, without  
17 taking any further regulatory action, may implement, interpret, or  
18 make specific this section by means of informational letters,  
19 bulletins, or similar instructions.

20 (7) The commission shall provide a status report to the fiscal  
21 and policy committees of the Legislature on the progress of  
22 implementation no later than March 1, 2014.

23 *(h) Funds appropriated by the Legislature to the commission*  
24 *pursuant to paragraph (8) of subdivision (b) for the purposes of*  
25 *addressing children's crisis services shall be allocated to support*  
26 *triage personnel and family supportive training and related*  
27 *services. These funds shall be made available to selected counties,*  
28 *counties acting jointly, or city mental health departments, as*  
29 *determined by the commission through a selection process. The*  
30 *commission may, at its discretion, also give consideration to*  
31 *private nonprofit corporations and public agencies in an area or*  
32 *region of the state if a county, or counties acting jointly,*  
33 *affirmatively supports this designation and collaboration in lieu*  
34 *of a county government directly receiving grant funds.*

35 *(1) These funds may provide for a range of crisis-related*  
36 *services for a child in need of assistance, or his or her parent,*  
37 *guardian, or caregiver. These service activities may include, but*  
38 *are not limited to, the following:*

39 *(A) Intensive coordination of care and services.*

40 *(B) Communication, coordination, and referral.*

1 (C) *Monitoring service delivery to the child or youth.*

2 (D) *Monitoring the child's progress.*

3 (E) *Providing placement service assistance and service plan*  
4 *development.*

5 (F) *Crisis or safety planning.*

6 (2) *The commission shall take into account at least the following*  
7 *criteria and factors when selecting recipients and determining the*  
8 *amount of grant awards for these funds, as follows:*

9 (A) *Description of need, including potential gaps in local service*  
10 *connections.*

11 (B) *Description of funding request, including personnel.*

12 (C) *Description of how personnel and other services will be*  
13 *used to facilitate linkage and access to services, including*  
14 *objectives and anticipated outcomes.*

15 (D) *Ability to obtain federal Medicaid reimbursement, when*  
16 *applicable.*

17 (E) *Ability to provide a matching contribution of local funds.*

18 (F) *Ability to administer an effective service program and the*  
19 *degree to which local agencies and service providers will support*  
20 *and collaborate with the triage personnel effort.*

21 (G) *Geographic areas or regions of the state to be eligible for*  
22 *grant awards, which shall include rural, suburban, and urban*  
23 *areas, and may include use of the five regional designations utilized*  
24 *by the County Behavioral Health Directors Association of*  
25 *California.*

26 (3) *The commission shall determine maximum grant awards,*  
27 *and shall take into consideration the level of need, population to*  
28 *be served, and related criteria, as described in paragraph (2), and*  
29 *shall reflect reasonable costs.*

30 (4) *Funds awarded by the commission for purposes of this*  
31 *section may be used to supplement, but not supplant, existing*  
32 *financial and resource commitments of the county, counties acting*  
33 *jointly, or a city mental health department that received the grant.*

34 (5) *Notwithstanding any other law, a county, counties acting*  
35 *jointly, or a city mental health department that receives an award*  
36 *of funds for the purpose of this section is not required to provide*  
37 *a matching contribution of local funds.*

38 (6) *Notwithstanding any other law, the commission, without*  
39 *taking any further regulatory action, may implement, interpret, or*

1 *make specific this section by means of informational letters,*  
2 *bulletins, or similar instructions.*

3 *(7) The commission may waive requirements in this section for*  
4 *counties with a population of 100,000 or less, if the commission*  
5 *determines it is in the best interest of the state and meets the intent*  
6 *of the law.*

7 *(8) The commission shall provide a status report to the fiscal*  
8 *and policy committees of the Legislature on the progress of*  
9 *implementation no later than January 10, 2018, and annually*  
10 *thereafter.*

11 *SEC. 21. Section 10752 of the Welfare and Institutions Code*  
12 *is amended to read:*

13 *10752. The department shall, by March 1, 2017, in coordination*  
14 *with the Department of Finance, ~~develop a funding plan that~~*  
15 *~~ensures adequate reimbursement to emergency medical air~~*  
16 *~~transportation providers following~~ notify the Legislature of the*  
17 *fiscal impact on the Medi-Cal program resulting from, and the*  
18 *planned reimbursement methodology for emergency medical air*  
19 *transportation services after, the termination of penalty*  
20 *assessments pursuant to subdivision (f) of Section 76000.10 of the*  
21 *Government Code on January 1, 2018.*

22 *SEC. 22. Section 14009.5 of the Welfare and Institutions Code*  
23 *is amended to read:*

24 *14009.5. (a) ~~Notwithstanding~~ It is the intent of the Legislature,*  
25 *with the amendments made to this section by the act that added*  
26 *subdivision (g), to do all of the following:*

27 *(1) Limit Medi-Cal estate recovery only for those services*  
28 *required to be collected under federal law.*

29 *(2) Limit the definition of “estate” to include only the real and*  
30 *personal property and other assets required to be collected under*  
31 *federal law.*

32 *(3) Require the State Department of Health Care Services to*  
33 *implement the option in the State Medicaid Manual to waive its*  
34 *claim, as a substantial hardship, when the estate subject to*  
35 *recovery is a homestead of modest value, subject to federal*  
36 *approval.*

37 *(4) Prohibit recovery from the estate of a deceased Medi-Cal*  
38 *member who is survived by a spouse or registered domestic*  
39 *partner.*

1     (5) *Ensure that Medi-Cal members can easily and timely receive*  
2 *information about how much their estate may owe Medi-Cal when*  
3 *they die.*

4     (b) *Notwithstanding any other provision of this chapter, the*  
5 *department shall claim against the estate of the decedent, or against*  
6 *any recipient of the property of that decedent by ~~distribution or~~*  
7 *~~survival~~ distribution, an amount equal to the payments for the*  
8 *health care services received or the value of the property received*  
9 *by any recipient from the decedent by ~~distribution or survival,~~*  
10 *~~whichever is less.~~ distribution, whichever is less, only in either of*  
11 *the following circumstances:*

12     ~~(b) The department may not claim in any of the following~~  
13 ~~circumstances:~~

14     ~~(1) The decedent was under 55 when services were received,~~  
15 ~~except in the case of an individual who had been an inpatient in a~~  
16 ~~nursing facility.~~

17     ~~(2) Where there is any of the following:~~

18     (1) *Against the real property of a Medi-Cal member of any age*  
19 *who meets the criteria in Section 1396p(a)(1)(B) of Title 42 of the*  
20 *United States Code and who was or is an inpatient in a nursing*  
21 *facility in accordance with Section 1396p(b)(1)(A) of Title 42 of*  
22 *the United States Code.*

23     (2) (A) *The decedent was 55 years of age or older when the*  
24 *individual received health care services.*

25     (B) *The department shall not claim under this paragraph when*  
26 *there is any of the following:*

27     (A)

28     (i) ~~A surviving spouse during his or her lifetime. However, upon~~  
29 ~~the death of a surviving spouse, the department shall make a claim~~  
30 ~~against the estate of the surviving spouse, or against any recipient~~  
31 ~~of property from the surviving spouse obtained by distribution or~~  
32 ~~survival, for either the amount paid for the medical assistance~~  
33 ~~given to the decedent or the value of any of the decedent's property~~  
34 ~~received by the surviving spouse through distribution or survival,~~  
35 ~~whichever is less. Any statute of limitations that purports to limit~~  
36 ~~the ability to recover for medical assistance granted under this~~  
37 ~~chapter shall not apply to any claim made for reimbursement.~~  
38 *spouse or surviving registered domestic partner.*

39     (B)

40     (ii) *A surviving child who is under age ~~21.~~ 21 years of age.*

1     ~~(C)~~

2     (iii) A surviving child who is blind or permanently and totally  
3 disabled, within the meaning of Section 1614 of the federal Social  
4 Security Act (42 U.S.C.A. U.S.C. Sec. 1382c).

5     ~~(3) Any exemption described in paragraph (2) that restricts the~~  
6 ~~department from filing a claim against a decedent's property shall~~  
7 ~~apply only to the proportionate share of the decedent's estate or~~  
8 ~~property that passes to those recipients, by survival or distribution,~~  
9 ~~who qualify for an exemption under paragraph (2).~~

10    (c) (1) The department shall waive its claim, in whole or in  
11 part, if it determines that enforcement of the claim would result in  
12 substantial hardship to other dependents, heirs, or survivors of the  
13 individual against whose estate the claim exists.

14    (2) *In determining the existence of substantial hardship, in*  
15 *addition to other factors considered by the department consistent*  
16 *with federal law and guidance, the department shall, subject to*  
17 *federal approval, waive its claim when the estate subject to*  
18 *recovery is a homestead of modest value.*

19    ~~(2)~~

20    (3) The department shall notify individuals of the waiver  
21 provision and the opportunity for a hearing to establish that a  
22 waiver should be granted.

23    (d) *If the department proposes and accepts a voluntary postdeath*  
24 *lien, the voluntary postdeath lien shall accrue interest at the rate*  
25 *equal to the annual average rate earned on investments in the*  
26 *Surplus Money Investment Fund in the calendar year preceding*  
27 *the year in which the decedent died or simple interest at 7 percent*  
28 *per annum, whichever is lower.*

29    (e) (1) *The department shall provide a current or former*  
30 *member, or his or her authorized representative designated under*  
31 *Section 14014.5, upon request, a copy of the amount of Medi-Cal*  
32 *expenses that may be recoverable under this section through the*  
33 *date of the request. The information may be requested once per*  
34 *calendar year for a fee to cover the department's reasonable*  
35 *administrative costs, not to exceed five dollars (\$5) if the current*  
36 *or former member meets either of the following descriptions:*

37    (A) *An individual who is 55 years of age or older when the*  
38 *individual received health care services.*

1 (B) A permanently institutionalized individual who is an  
2 inpatient in a nursing facility, intermediate care facility for the  
3 intellectually disabled, or other medical institution.

4 (2) The department shall permit a member to request the  
5 information described in paragraph (1) through the Internet, by  
6 telephone, by mail, or through other commonly available electronic  
7 means. Upon receipt of the request for information described in  
8 paragraph (1), the department shall work with the member to  
9 ensure that the member submits documentation necessary to  
10 identify the individual and process the member's request.

11 (3) The department shall conspicuously post on its Internet Web  
12 site a description of the methods by which a request under this  
13 subdivision may be made, including, but not limited to, the  
14 department's telephone number and any addresses that may be  
15 used for this purpose. The department shall also include this  
16 information in its pamphlet for the Medi-Cal Estate Recovery  
17 Program and any other notices the department distributes to  
18 members specifically regarding estate recovery.

19 (4) Upon receiving a request for the information described in  
20 paragraph (1) and all necessary supporting documentation, the  
21 department shall provide the information requested within 90 days  
22 after receipt of the request.

23 (d)

24 (f) The following definitions shall govern the construction of  
25 this section:

26 (1) "Decedent" means a ~~beneficiary member~~ who has received  
27 health care under this chapter or Chapter 8 (commencing with  
28 Section 14200) and who has died leaving property to others ~~either~~  
29 ~~through distribution or survival.~~ through distribution.

30 (2) "Dependents" includes, but is not limited to, immediate  
31 family or blood relatives of the decedent.

32 (3) "Estate" means all real and personal property and other  
33 assets in the individual's probate estate that are required to be  
34 subject to a claim for recovery pursuant to Section 1396p(b)(4)(A)  
35 of Title 42 of the United States Code.

36 (4) "Health care services" means only those services required  
37 to be recovered under Section 1396p(b)(1)(B)(i) of Title 42 of the  
38 United States Code.

39 (5) "Homestead of modest value" means a home whose fair  
40 market value is 50 percent or less of the average price of homes

1 *in the county where the homestead is located, as of the date of the*  
2 *decedent's death.*

3 *(g) The amendments made to this section by the act that added*  
4 *this subdivision shall apply only to individuals who die on or after*  
5 *January 1, 2017.*

6 *SEC. 23. Section 14046.7 of the Welfare and Institutions Code*  
7 *is amended to read:*

8 14046.7. (a) General Fund moneys shall not be used for the  
9 purposes of this article.

10 (b) Notwithstanding subdivision (a), no more than ~~two hundred~~  
11 ~~thousand dollars (\$200,000)~~ *four hundred twenty-five thousand*  
12 *dollars (\$425,000)* from the General Fund may be used annually  
13 for state administrative costs associated with implementing this  
14 article.

15 *SEC. 24. Section 14105.436 of the Welfare and Institutions*  
16 *Code is amended to read:*

17 14105.436. (a) Effective July 1, 2002, all pharmaceutical  
18 manufacturers shall provide to the department a state rebate, in  
19 addition to rebates pursuant to other provisions of state or federal  
20 law, for any drug products that have been added to the Medi-Cal  
21 list of contract drugs pursuant to Section 14105.43 or 14133.2 and  
22 reimbursed through the Medi-Cal outpatient fee-for-service drug  
23 program. The state rebate shall be negotiated as necessary between  
24 the department and the pharmaceutical manufacturer. The  
25 negotiations shall take into account offers such as rebates,  
26 discounts, disease management programs, and other cost savings  
27 offerings and shall be retroactive to July 1, 2002.

28 (b) The department may use existing administrative mechanisms  
29 for any drug for which the department does not obtain a rebate  
30 pursuant to subdivision (a). The department may only use those  
31 mechanisms in the event that, by February 1, 2003, the  
32 manufacturer refuses to provide the additional rebate. This  
33 subdivision shall become inoperative on January 1, 2010.

34 (c) For purposes of this section, "Medi-Cal utilization data"  
35 means the data used by the department to reimburse providers  
36 under all programs that qualify for federal drug rebates pursuant  
37 to Section 1927 of the federal Social Security Act (42 U.S.C. Sec.  
38 1396r-8) or that otherwise qualify for federal funds under Title  
39 XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et  
40 seq.) pursuant to the Medicaid state plan or waivers. Medi-Cal

utilization data excludes data from covered entities identified in Section 256b(a)(4) of Title 42 of the United States Code in accordance with Sections 256b(a)(5)(A) and 1396r-8(a)(5)(C) of Title 42 of the United States Code, and those capitated plans that include a prescription drug benefit in the capitated rate and that have negotiated contracts for rebates or discounts with manufacturers.

~~(d) Subdivision—Upon implementation of paragraphs (4) and (5) of subdivision (b) of Section 14105.33 for drugs pursuant to this section, subdivisions (a) and (c) shall become inoperative when the department implements paragraphs (4) and (5) of and “utilization data” shall be described pursuant to subdivision (b) of Section 14105.33. The department shall post on its Internet Web site a notice that it has implemented paragraphs (4) and (5) of subdivision (b) of Section 14105.33. 14105.33 for drugs pursuant to this section.~~

(e) Effective July 1, 2009, all pharmaceutical manufacturers shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, equal to an amount not less than 10 percent of the average manufacturer price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2.

(f) Pharmaceutical manufacturers shall, by January 1, 2010, enter into a supplemental rebate agreement for the rebate required in subdivision ~~(d)~~ (e) for drug products added to the Medi-Cal list of contract drugs on or before December 31, 2009.

(g) Effective January 1, 2010, all pharmaceutical manufacturers who have not entered into a supplemental rebate agreement pursuant to subdivisions ~~(d)~~ (e) and ~~(e)~~, (f) shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, equal to an amount not less than 20 percent of the average manufacturer price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 prior to January 1, 2010. If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement by March 1, 2010, the manufacturer’s drug product shall be made available only through an approved treatment authorization request pursuant to subdivision ~~(h)~~: (i).

1 (h) For a drug product added to the Medi-Cal list of contract  
2 drugs pursuant to Section 14105.43 or 14133.2 on or after January  
3 1, 2010, a pharmaceutical manufacturer shall provide to the  
4 department a state rebate pursuant to subdivision ~~(d)~~. *(e)*. If the  
5 pharmaceutical manufacturer does not enter into a supplemental  
6 rebate agreement within 60 days after the addition of the drug to  
7 the Medi-Cal list of contract drugs, the manufacturer shall provide  
8 to the department a state rebate equal to not less than 20 percent  
9 of the average manufacturers price based on Medi-Cal utilization  
10 data for any drug products that have been added to the Medi-Cal  
11 list of contract drugs pursuant to Section 14105.43 or 14133.2. If  
12 the pharmaceutical manufacturer does not enter into a supplemental  
13 rebate agreement within 120 days after the addition of the drug to  
14 the Medi-Cal list of contract drugs, the pharmaceutical  
15 manufacturer's drug product shall be made available only through  
16 an approved treatment authorization request pursuant to subdivision  
17 ~~(h)~~. *(i)*. For supplemental rebate agreements executed more than  
18 120 days after the addition of the drug product to the Medi-Cal  
19 list of contract drugs, the state rebate shall equal an amount not  
20 less than 20 percent of the average manufacturers price based on  
21 Medi-Cal utilization data for any drug products that have been  
22 added to the Medi-Cal list of contract drugs pursuant to Section  
23 14105.43 or 14133.2.

24 (i) Notwithstanding any other ~~provision of~~ law, drug products  
25 added to the Medi-Cal list of contract drugs pursuant to Section  
26 14105.43 or 14133.2 of manufacturers who do not execute an  
27 agreement to pay additional rebates pursuant to this ~~section~~, *section*  
28 shall be available only through an approved treatment authorization  
29 request.

30 (j) For drug products added on or before December 31, 2009,  
31 a beneficiary may obtain a drug product that requires a treatment  
32 authorization request pursuant to subdivision ~~(h)~~ *(i)* if the  
33 beneficiary qualifies for continuing care status. To be eligible for  
34 continuing care status, a beneficiary must be taking the drug  
35 product and the department must have record of a reimbursed claim  
36 for the drug product with a date of service that is within 100 days  
37 prior to the date the drug product was placed on treatment  
38 authorization request status. A beneficiary may remain eligible for  
39 continuing care status, provided that a claim is submitted for the  
40 drug product in question at least every 100 days and the date of

1 service of the claim is within 100 days of the date of service of the  
2 last claim submitted for the same drug product.

3 (k) Changes made to the Medi-Cal list of contract drugs under  
4 this section shall be exempt from the requirements of the  
5 Administrative Procedure Act (Chapter 3.5 (commencing with  
6 Section 11340), Chapter 4 (commencing with Section 11370), and  
7 Chapter 5 (commencing with Section 11500) of Part 1 of Division  
8 3 of Title 2 of the Government Code), and shall not be subject to  
9 the review and approval of the Office of Administrative Law.

10 *SEC. 25. Section 14105.45 of the Welfare and Institutions Code*  
11 *is amended to read:*

12 14105.45. (a) For purposes of this section, the following  
13 definitions shall apply:

14 (1) "Average acquisition cost" means the average weighted cost  
15 determined by the department to represent the actual acquisition  
16 cost paid for drugs by Medi-Cal pharmacy providers, including  
17 those that provide specialty drugs. The average acquisition cost  
18 shall not be considered confidential and shall be subject to  
19 disclosure pursuant to the California Public Records Act (Chapter  
20 3.5 (commencing with Section 6250) of Division 7 of Title 1 of  
21 the Government Code).

22 (2) "Average manufacturers price" means the price reported to  
23 the department by the federal Centers for Medicare and Medicaid  
24 Services pursuant to Section 1927 of the Social Security Act (42  
25 U.S.C. Sec. 1396r-8).

26 (3) "Average wholesale price" means the price for a drug  
27 product listed as the average wholesale price in the department's  
28 primary price reference source.

29 (4) "Estimated acquisition cost" means the department's best  
30 estimate of the price generally and currently paid by providers for  
31 a drug product sold by a particular manufacturer or principal labeler  
32 in a standard package.

33 (5) "Federal upper limit" means the maximum per unit  
34 reimbursement when established by the federal Centers for  
35 Medicare and Medicaid Services and published by the department  
36 ~~in Medi-Cal pharmacy provider bulletins and manuals.~~ *Services.*

37 (6) "Generically equivalent drugs" means drug products with  
38 the same active chemical ingredients of the same strength and  
39 dosage form, and of the same generic drug name, as determined  
40 by the United States Adopted Names (USAN) and accepted by the

1 federal Food and Drug Administration (FDA), as those drug  
2 products having the same chemical ingredients.

3 (7) “Legend drug” means any drug whose labeling states  
4 “Caution: Federal law prohibits dispensing without prescription,”  
5 “Rx only,” or words of similar import.

6 (8) “Maximum allowable ingredient cost” (MAIC) means the  
7 maximum amount the department will reimburse Medi-Cal  
8 pharmacy providers for generically equivalent drugs.

9 (9) “Innovator multiple source drug,” “noninnovator multiple  
10 source drug,” and “single source drug” have the same meaning as  
11 those terms are defined in Section 1396r-8(k)(7) of Title 42 of the  
12 United States Code.

13 (10) “Nonlegend drug” means any drug whose labeling does  
14 not contain the statement referenced in paragraph (7).

15 (11) “Pharmacy warehouse,” as defined in Section 4163 of the  
16 Business and Professions Code, means a physical location licensed  
17 as a wholesaler for prescription drugs that acts as a central  
18 warehouse and performs intracompany sales or transfers of those  
19 drugs to a group of pharmacies under common ownership and  
20 control.

21 (12) *“Professional dispensing fee” has the same meaning as*  
22 *that term is defined in Section 447.502 of Title 42 of the Code of*  
23 *Federal Regulations.*

24 ~~(12)~~

25 (13) “Specialty drugs” means drugs determined by the  
26 department pursuant to subdivision (f) of Section 14105.3 to  
27 generally require special handling, complex dosing regimens,  
28 specialized self-administration at home by a beneficiary or  
29 caregiver, or specialized nursing facility services, or may include  
30 extended patient education, counseling, monitoring, or clinical  
31 support.

32 ~~(13)~~

33 (14) “Volume weighted average” means the aggregated average  
34 volume for a group of legend or nonlegend drugs, weighted by  
35 each drug’s percentage of the group’s total volume in the Medi-Cal  
36 fee-for-service program during the previous six months. For  
37 purposes of this paragraph, volume is based on the standard billing  
38 unit used for the legend or nonlegend drugs.

39 ~~(14)~~

1 (15) “Wholesaler” means a drug wholesaler that is engaged in  
2 wholesale distribution of prescription drugs to retail pharmacies  
3 in California.

4 ~~(15)~~

5 (16) “Wholesaler acquisition cost” means the price for a drug  
6 product listed as the wholesaler acquisition cost in the department’s  
7 primary price reference source.

8 (b) (1) Reimbursement to Medi-Cal pharmacy providers for  
9 legend and nonlegend drugs shall not exceed the lowest of either  
10 of the following:

11 (A) The estimated acquisition cost of the drug plus a professional  
12 ~~fee for dispensing.~~ *dispensing fee.*

13 (B) The pharmacy’s usual and customary charge as defined in  
14 Section 14105.455.

15 ~~(2) The professional~~ *(A) Until April 1, 2017, the professional*  
16 *dispensing fee shall be seven dollars and twenty-five cents (\$7.25)*  
17 *per dispensed prescription. The professional prescription, and the*  
18 *professional dispensing fee for legend drugs dispensed to a*  
19 *beneficiary residing in a skilled nursing facility or intermediate*  
20 *care facility shall be eight dollars (\$8) per dispensed prescription.*  
21 *For purposes of this paragraph, “skilled nursing facility”*  
22 *and “intermediate care facility” shall have the same meaning as*  
23 *those terms are defined in Division 5 (commencing with Section*  
24 *70001) of Title 22 of the California Code of Regulations. If the*  
25 *department determines that a change in dispensing fee is necessary*  
26 *pursuant to this section, the department shall establish the new*  
27 *dispensing fee through the budget process and implement the new*  
28 *dispensing fee pursuant to subdivision (d).*

29 *(B) Commencing April 1, 2017, the department shall implement*  
30 *a new professional dispensing fee or fees.*

31 *(i) When establishing the new professional dispensing fee or*  
32 *fees, the department shall establish the professional dispensing*  
33 *fee or fees consistent with subdivision (d) of Section 447.518 of*  
34 *Title 42 of the Code of Federal Regulations.*

35 *(ii) The department shall consult with interested parties and*  
36 *appropriate stakeholders in implementing this subparagraph.*

37 *(C) If the department determines that a change in the amount*  
38 *of a professional dispensing fee is necessary pursuant to this*  
39 *section in order to meet federal Medicaid requirements, the*

1 *department shall establish the new professional dispensing fee*  
2 *through the state budget process.*

3 (3) The department shall establish the estimated acquisition cost  
4 of legend and nonlegend drugs as follows:

5 (A) For single source and innovator multiple source drugs, the  
6 estimated acquisition cost shall be equal to the lowest of the  
7 average wholesale price minus 17 percent, the average acquisition  
8 cost, the federal upper limit, or the MAIC.

9 (B) For noninnovator multiple source drugs, the estimated  
10 acquisition cost shall be equal to the lowest of the average  
11 wholesale price minus 17 percent, the average acquisition cost,  
12 the federal upper limit, or the MAIC.

13 (C) Average wholesale price shall not be used to establish the  
14 estimated acquisition cost once the department has determined  
15 that the average acquisition cost methodology has been fully  
16 implemented.

17 (4) For purposes of paragraph (3), the department shall establish  
18 a list of MAICs for generically equivalent drugs, which shall be  
19 published in pharmacy provider bulletins and manuals. The  
20 department shall establish a MAIC only when three or more  
21 generically equivalent drugs are available for purchase and  
22 dispensing by retail pharmacies in California. The department shall  
23 update the list of MAICs and establish additional MAICs in  
24 accordance with all of the following:

25 (A) The department shall base the MAIC on the mean of the  
26 average manufacturer's price of drugs generically equivalent to  
27 the particular innovator drug plus a percent markup determined  
28 by the department to be necessary for the MAIC to represent the  
29 average purchase price paid by retail pharmacies in California.

30 (B) If average manufacturer prices are unavailable, the  
31 department shall establish the MAIC in one of the following ways:

32 (i) Based on the volume weighted average of wholesaler  
33 acquisition costs of drugs generically equivalent to the particular  
34 innovator drug plus a percent markup determined by the department  
35 to be necessary for the MAIC to represent the average purchase  
36 price paid by retail pharmacies in California.

37 (ii) Pursuant to a contract with a vendor for the purpose of  
38 surveying drug price information, collecting data, and calculating  
39 a proposed MAIC.

1 (iii) Based on the volume weighted average acquisition cost of  
2 drugs generically equivalent to the particular innovator drug  
3 adjusted by the department to represent the average purchase price  
4 paid by Medi-Cal pharmacy providers.

5 (C) The department shall update MAICs at least every three  
6 months and notify Medi-Cal providers at least 30 days prior to the  
7 effective date of a MAIC.

8 (D) The department shall establish a process for providers to  
9 seek a change to a specific MAIC when the providers believe the  
10 MAIC does not reflect current available market prices. If the  
11 department determines a MAIC change is warranted, the  
12 department may update a specific MAIC prior to notifying  
13 providers.

14 (E) In determining the average purchase price, the department  
15 shall consider the provider-related costs of the products that  
16 include, but are not limited to, shipping, handling, storage, and  
17 delivery. Costs of the provider that are included in the costs of the  
18 dispensing shall not be used to determine the average purchase  
19 price.

20 (5) (A) The department may establish the average acquisition  
21 cost in one of the following ways:

22 (i) Based on the volume weighted average acquisition cost  
23 adjusted by the department to ensure that the average acquisition  
24 cost represents the average purchase price paid by retail pharmacies  
25 in California.

26 (ii) Based on the proposed average acquisition cost as calculated  
27 by the vendor pursuant to subparagraph (B).

28 (iii) Based on a national pricing benchmark obtained from the  
29 federal Centers for Medicare and Medicaid Services or on a similar  
30 benchmark listed in the department's primary price reference  
31 source adjusted by the department to ensure that the average  
32 acquisition cost represents the average purchase price paid by retail  
33 pharmacies in California.

34 (B) For the purposes of paragraph (3), the department may  
35 contract with a vendor for the purposes of surveying drug price  
36 information, collecting data from providers, wholesalers, or drug  
37 manufacturers, and calculating a proposed average acquisition  
38 cost.

39 (C) (i) Medi-Cal pharmacy providers shall submit drug price  
40 information to the department or a vendor designated by the

1 department for the purposes of establishing the average acquisition  
2 cost. The information submitted by pharmacy providers shall  
3 include, but not be limited to, invoice prices and all discounts,  
4 rebates, and refunds known to the provider that would apply to the  
5 acquisition cost of the drug products purchased during the calendar  
6 quarter. Pharmacy warehouses shall be exempt from the survey  
7 process, but shall provide drug cost information upon audit by the  
8 department for the purposes of validating individual pharmacy  
9 provider acquisition costs.

10 (ii) Pharmacy providers that fail to submit drug price information  
11 to the department or the vendor as required by this subparagraph  
12 shall receive notice that if they do not provide the required  
13 information within five working days, they shall be subject to  
14 suspension under subdivisions (a) and (c) of Section 14123.

15 (D) (i) For new drugs or new formulations of existing drugs,  
16 ~~where~~ *if* drug price information is unavailable pursuant to clause  
17 (i) of subparagraph (C), drug manufacturers and wholesalers shall  
18 submit drug price information to the department or a vendor  
19 designated by the department for the purposes of establishing the  
20 average acquisition cost. Drug price information shall include, but  
21 not be limited to, net unit sales of a drug product sold to retail  
22 pharmacies in California divided by the total number of units of  
23 the drug sold by the manufacturer or wholesaler in a specified  
24 period of time determined by the department.

25 (ii) Drug products from manufacturers and wholesalers that fail  
26 to submit drug price information to the department or the vendor  
27 as required by this subparagraph ~~may~~ *shall* not be a reimbursable  
28 benefit of the Medi-Cal program for those manufacturers and  
29 wholesalers until the department has established the average  
30 acquisition cost for those drug products.

31 (E) Drug pricing information provided to the department or a  
32 vendor designated by the department for the purposes of  
33 establishing the average acquisition cost pursuant to this section  
34 shall be confidential and shall be exempt from disclosure under  
35 the California Public Records Act (Chapter 3.5 (commencing with  
36 Section 6250) of Division 7 of Title 1 of the Government Code).

37 (F) Prior to the implementation of an average acquisition cost  
38 methodology, the department shall collect data through a survey  
39 of pharmacy providers for purposes of establishing a professional

1 ~~fee for dispensing~~ *dispensing fee or fees* in compliance with federal  
2 Medicaid requirements.

3 (i) The department shall seek stakeholder input on the retail  
4 pharmacy factors and elements used for the pharmacy survey  
5 relative to both average acquisition costs and ~~dispensing costs~~.  
6 ~~Any adjustment to the dispensing fee shall not exceed the aggregate~~  
7 ~~savings associated with the implementation of the average~~  
8 ~~acquisition cost methodology.~~ *professional dispensing costs.*

9 (ii) For drug products provided by pharmacy providers pursuant  
10 to subdivision (f) of Section 14105.3, a differential professional  
11 fee or payment for services to provide specialized care may be  
12 considered as part of the contracts established pursuant to that  
13 section.

14 (G) When the department implements the average acquisition  
15 cost methodology, the department shall update the Medi-Cal claims  
16 processing system to reflect the average acquisition cost of drugs  
17 not later than 30 days after the department has established average  
18 acquisition cost pursuant to subparagraph (A).

19 (H) Notwithstanding any other ~~provision~~ of law, if the  
20 department implements average acquisition cost pursuant to clause  
21 (i) or (ii) of subparagraph (A), the department shall update actual  
22 acquisition costs at least every three months and notify Medi-Cal  
23 providers at least 30 days prior to the effective date of any change  
24 in an actual acquisition cost.

25 (I) The department shall establish a process for providers to  
26 seek a change to a specific average acquisition cost when the  
27 providers believe the average acquisition cost does not reflect  
28 current available market prices. If the department determines an  
29 average acquisition cost change is warranted, the department may  
30 update a specific average acquisition cost prior to notifying  
31 providers.

32 (c) The director shall implement this section in a manner that  
33 is consistent with federal Medicaid law and regulations. The  
34 director shall seek any necessary federal approvals for the  
35 implementation of this section. This section shall be implemented  
36 only to the extent that federal approval is obtained.

37 (d) Notwithstanding Chapter 3.5 (commencing with Section  
38 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
39 the department may implement, interpret, or make specific this

1 section by means of a provider bulletin or notice, policy letter, or  
2 other similar instructions, without taking regulatory action.

3 (e) The department may enter into contracts with a vendor for  
4 the purposes of implementing this section on a bid or nonbid basis.  
5 In order to achieve maximum cost savings, the Legislature declares  
6 that an expedited process for contracts under this section is  
7 necessary. Therefore, contracts entered into to implement this  
8 section, and all contract amendments and change orders, shall be  
9 exempt from Chapter 2 (commencing with Section 10290) of Part  
10 2 of Division 2 of the Public Contract Code.

11 (f) (1) The rates provided for in this section shall be  
12 implemented only if the director determines that the rates will  
13 comply with applicable federal Medicaid requirements and that  
14 federal financial participation will be available.

15 (2) In determining whether federal financial participation is  
16 available, the director shall determine whether the rates comply  
17 with applicable federal Medicaid requirements, including those  
18 set forth in Section 1396a(a)(30)(A) of Title 42 of the United States  
19 Code.

20 (3) To the extent that the director determines that the rates do  
21 not comply with applicable federal Medicaid requirements or that  
22 federal financial participation is not available with respect to any  
23 rate of reimbursement described in this section, the director retains  
24 the discretion not to implement that rate and may revise the rate  
25 as necessary to comply with federal Medicaid requirements.

26 (g) The director shall seek any necessary federal approvals for  
27 the implementation of this section.

28 (h) This section shall not be construed to require the department  
29 to collect cost data, to conduct cost studies, or to set or adjust a  
30 rate of reimbursement based on cost data that has been collected.

31 (i) Adjustments to pharmacy drug product payment pursuant to  
32 Section 14105.192 shall no longer apply when the department  
33 determines that the average acquisition cost methodology has been  
34 fully implemented and the department's pharmacy budget reduction  
35 targets, consistent with payment reduction levels pursuant to  
36 Section 14105.192, have been met.

37 (j) Prior to implementation of this section, the department shall  
38 provide the appropriate fiscal and policy committees of the  
39 Legislature with information on the department's plan for

1 implementation of the average acquisition cost methodology  
2 pursuant to this section.

3 *SEC. 26. Section 14105.456 of the Welfare and Institutions*  
4 *Code is amended to read:*

5 14105.456. (a) For purposes of this section, the following  
6 definitions shall apply:

7 (1) "Generically equivalent drugs" means drug products with  
8 the same active chemical ingredients of the same strength, quantity,  
9 and dosage form, and of the same generic drug name, as determined  
10 by the United States Adopted Names Council (USANC) and  
11 accepted by the federal Food and Drug Administration (FDA), as  
12 those drug products having the same chemical ingredients.

13 (2) "Legend drug" means any drug with a label that states  
14 "Caution: Federal law prohibits dispensing without prescription,"  
15 "Rx only," or words of similar import.

16 (3) "Medicare rate" means the rate of reimbursement established  
17 by the Centers for Medicare and Medicaid Services for the  
18 Medicare Program.

19 (4) "Nonlegend drug" means any drug with a label that does  
20 not contain a statement referenced in paragraph (2).

21 (5) "Pharmacy rate of reimbursement" means the reimbursement  
22 to a Medi-Cal pharmacy provider pursuant to the provisions of  
23 paragraph ~~(2)~~ (3) of subdivision (b) of Section 14105.45.

24 (6) "Physician-administered drug" means any legend drug,  
25 nonlegend drug, or vaccine administered or dispensed to a  
26 beneficiary by a Medi-Cal provider other than a pharmacy provider  
27 and billed to the department on a fee-for-service basis.

28 (7) "Volume-weighted average" means the aggregated average  
29 volume for generically equivalent drugs, weighted by each drug's  
30 percentage of the total volume in the Medi-Cal fee-for-service  
31 program during the previous six months. For purposes of this  
32 paragraph, volume is based on the standard billing unit used for  
33 the generically equivalent drugs.

34 (b) The department may reimburse providers for a  
35 physician-administered drug using either a Healthcare Common  
36 Procedure Coding System code or a National Drug Code.

37 (c) The Healthcare Common Procedure Coding System code  
38 rate of reimbursement for a physician-administered drug shall be  
39 equal to the volume-weighted average of the pharmacy rate of  
40 reimbursement for generically equivalent drugs. The department

1 shall publish the Healthcare Common Procedure Coding System  
2 code rates of reimbursement.

3 (d) The National Drug Code rate of reimbursement shall equal  
4 the pharmacy rate of reimbursement.

5 (e) Notwithstanding subdivisions (c) and (d), the department  
6 may reimburse providers for physician-administered drugs at a  
7 rate not less than the Medicare rate.

8 (f) Notwithstanding Chapter 3.5 (commencing with Section  
9 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
10 the department may implement this section by means of a provider  
11 bulletin or notice, policy letter, or other similar instructions, without  
12 taking regulatory action.

13 (g) (1) The rates provided for in this section shall be  
14 implemented commencing January 1, 2011, but only if the director  
15 determines that the rates comply with applicable federal Medicaid  
16 requirements and that federal financial participation will be  
17 available.

18 (2) In assessing whether federal financial participation is  
19 available, the director shall determine whether the rates comply  
20 with the federal Medicaid requirements, including those set forth  
21 in Section 1396a(a)(30)(A) of Title 42 of the United States Code.  
22 To the extent that the director determines that a rate of  
23 reimbursement described in this section does not comply with the  
24 federal Medicaid requirements, the director retains the discretion  
25 not to implement that rate and may revise the rate as necessary to  
26 comply with the federal Medicaid requirements.

27 (h) The director shall seek any necessary federal approval for  
28 the implementation of this section. To the extent that federal  
29 financial participation is not available with respect to a rate of  
30 reimbursement described in this section, the director retains the  
31 discretion not to implement that rate and may revise the rate as  
32 necessary to comply with the federal Medicaid requirements.

33 *SEC. 27. Section 14105.86 of the Welfare and Institutions Code*  
34 *is amended to read:*

35 14105.86. (a) For the purposes of this section, the following  
36 definitions apply:

37 (1) (A) "Average sales price" means the price reported to the  
38 federal Centers for Medicare and Medicaid Services by the  
39 manufacturer pursuant to Section 1847A of the federal Social  
40 Security Act (42 U.S.C. Sec. 1395w-3a).

1 (B) "Average manufacturer price" means the price reported to  
2 the federal Centers for Medicare and Medicaid Services pursuant  
3 to Section 1927 of the federal Social Security Act (42 U.S.C. Sec.  
4 1396r-8).

5 (2) "Blood factors" means plasma protein therapies and their  
6 recombinant analogs. Blood factors include, but are not limited  
7 to, all of the following:

8 (A) Coagulation factors, including:

9 (i) Factor VIII, nonrecombinant.

10 (ii) Factor VIII, porcine.

11 (iii) Factor VIII, recombinant.

12 (iv) Factor IX, nonrecombinant.

13 (v) Factor IX, complex.

14 (vi) Factor IX, recombinant.

15 (vii) Antithrombin III.

16 (viii) Anti-inhibitor factor.

17 (ix) Von Willebrand factor.

18 (x) Factor VIIa, recombinant.

19 (B) Immune Globulin Intravenous.

20 (C) Alpha-1 Proteinase Inhibitor.

21 (b) The reimbursement for blood factors shall be by national  
22 drug code number and shall not exceed 120 percent of the average  
23 sales price of the last quarter reported.

24 (c) The average sales price for blood factors of manufacturers  
25 or distributors that do not report an average sales price pursuant  
26 to subdivision (a) shall be identical to the average manufacturer  
27 price. The average sales price for new products that do not have  
28 a calculable average sales price or average manufacturer price  
29 shall be equal to a projected sales price, as reported by the  
30 manufacturer to the department. Manufacturers reporting a  
31 projected sales price for a new product shall report the first monthly  
32 average manufacturer price reported to the federal Centers for  
33 Medicare and Medicaid Services. The reporting of an average sales  
34 price that does not meet the requirement of this subdivision shall  
35 result in that blood factor no longer being considered a covered  
36 benefit.

37 (d) The average sales price shall be reported at the national drug  
38 code level to the department on a quarterly basis.

39 (e) (1) Effective July 1, 2008, the department shall collect a  
40 state rebate, in addition to rebates pursuant to other provisions of

1 state or federal law, for blood factors reimbursed pursuant to this  
2 section by programs that qualify for federal drug rebates pursuant  
3 to Section 1927 of the federal Social Security Act (42 U.S.C. Sec.  
4 1396r-8) or otherwise qualify for federal funds under Title XIX  
5 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.)  
6 pursuant to the Medicaid state plan or waivers and the programs  
7 authorized by Article 5 (commencing with Section 123800) of  
8 Chapter 3 of Part 2 of, and Article 1 (commencing with Section  
9 125125) of Chapter 2 of Part 5 of, Division 106 of the Health and  
10 Safety Code.

11 (2) ~~Paragraph (1) shall become inoperative when the department~~  
12 ~~implements~~ *Upon implementation of paragraphs (4) and (5) of*  
13 ~~subdivision (b) of Section 14105.33. 14105.33 for blood factors~~  
14 *pursuant to this section, "utilization data" used to determine the*  
15 *state rebate shall be described pursuant to subdivision (b) of*  
16 *Section 14105.33. The department shall post on its Internet Web*  
17 *site a notice that it has implemented paragraphs (4) and (5) of*  
18 *subdivision (b) of Section 14105.33. 14105.33 for blood factors*  
19 *pursuant to this section.*

20 (3) The state rebate shall be negotiated as necessary between  
21 the department and the manufacturer. Manufacturers who do not  
22 execute an agreement to pay additional rebates pursuant to this  
23 section shall have their blood factors available only through an  
24 approved treatment or service authorization request. All blood  
25 factors that meet the definition of a covered outpatient drug  
26 pursuant to Section 1927 of the federal Social Security Act (42  
27 U.S.C. Sec. 1396r-8) shall remain a benefit subject to the utilization  
28 controls provided for in this section.

29 (4) In reviewing authorization requests, the department shall  
30 approve the lowest net cost product that meets the beneficiary's  
31 medical need. The review of medical need shall take into account  
32 a beneficiary's clinical history or the use of the blood factor  
33 pursuant to payment by another third party, or both.

34 (f) A beneficiary may obtain blood factors that require a  
35 treatment or service authorization request pursuant to subdivision  
36 (e) if the beneficiary qualifies for continuing care status. To be  
37 eligible for continuing care status, a beneficiary must be taking  
38 the blood factor and the department has reimbursed a claim for  
39 the blood factor with a date of service that is within 100 days prior  
40 to the date the blood factor was placed on treatment authorization

request status. A beneficiary may remain eligible for continuing care status, provided that a claim is submitted for the blood factor in question at least every 100 days and the date of service of the claim is within 100 days of the date of service of the last claim submitted for the same blood factor.

(g) Changes made to the list of covered blood factors under this or any other section shall be exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law.

*SEC. 28. Section 14131.10 of the Welfare and Institutions Code is amended to read:*

14131.10. (a) Notwithstanding any other provision of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591), in order to implement changes in the level of funding for health care services, specific optional benefits are excluded from coverage under the Medi-Cal program.

(b) (1) The following optional benefits are excluded from coverage under the Medi-Cal program:

(A) Adult dental services, except as specified in paragraph (2).

~~(B) Acupuncture services.~~

~~(C)~~

(B) Audiology services and speech therapy services.

~~(D)~~

(C) Chiropractic services.

~~(E)~~

(D) Optometric and optician services, including services provided by a fabricating optical laboratory.

~~(F)~~

(E) Podiatric services.

~~(G)~~

(F) Psychology services.

~~(H)~~

(G) Incontinence creams and washes.

(2) (A) Medical and surgical services provided by a doctor of dental medicine or dental surgery, which, if provided by a physician, would be considered physician services, and which

1 services may be provided by either a physician or a dentist in this  
2 state, are covered.

3 (B) Emergency procedures are also covered in the categories  
4 of service specified in subparagraph (A). The director may adopt  
5 regulations for any of the services specified in subparagraph (A).

6 (C) Effective May 1, 2014, or the effective date of any necessary  
7 federal approvals as required by subdivision (f), whichever is later,  
8 for persons 21 years of age or older, adult dental benefits, subject  
9 to utilization controls, are limited to all the following medically  
10 necessary services:

11 (i) Examinations, radiographs/photographic images, prophylaxis,  
12 and fluoride treatments.

13 (ii) Amalgam and composite restorations.

14 (iii) Stainless steel, resin, and resin window crowns.

15 (iv) Anterior root canal therapy.

16 (v) Complete dentures, including immediate dentures.

17 (vi) Complete denture adjustments, repairs, and relines.

18 (D) Services specified in this paragraph shall be included as a  
19 covered medical benefit under the Medi-Cal program pursuant to  
20 Section 14132.89.

21 (3) Pregnancy-related services and services for the treatment of  
22 other conditions that might complicate the pregnancy are not  
23 excluded from coverage under this section.

24 (c) The optional benefit exclusions do not apply to either of the  
25 following:

26 (1) Beneficiaries under the Early and Periodic Screening  
27 Diagnosis and Treatment Program.

28 (2) Beneficiaries receiving long-term care in a nursing facility  
29 that is both:

30 (A) A skilled nursing facility or intermediate care facility as  
31 defined in subdivisions (c) and (d) of Section 1250 of the Health  
32 and Safety Code.

33 (B) Licensed pursuant to subdivision (k) of Section 1250 of the  
34 Health and Safety Code.

35 (d) This section shall only be implemented to the extent  
36 permitted by federal law.

37 (e) Notwithstanding Chapter 3.5 (commencing with Section  
38 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
39 the department may implement the provisions of this section by

1 means of all-county letters, provider bulletins, or similar  
2 instructions, without taking further regulatory action.

3 ~~(f) The department shall seek approval for federal financial~~  
4 ~~participation and coverage of services specified in subparagraph~~  
5 ~~(C) of paragraph (2) of subdivision (b) under the Medi-Cal~~  
6 ~~program.~~

7 ~~(g) This section, except as specified in subparagraph (C) of~~  
8 ~~paragraph (2) of subdivision (b), shall be implemented on the first~~  
9 ~~day of the month following 90 days after the operative date of this~~  
10 ~~section.~~

11 *(f) This section shall be implemented only to the extent that*  
12 *federal financial participation is available and any necessary*  
13 *federal approvals have been obtained.*

14 *SEC. 29. Section 14132.56 of the Welfare and Institutions Code*  
15 *is amended to read:*

16 14132.56. (a) (1) Only to the extent required by the federal  
17 government and effective no sooner than required by the federal  
18 government, behavioral health treatment (BHT), as defined by  
19 Section 1374.73 of the Health and Safety Code, shall be a covered  
20 Medi-Cal service for individuals under 21 years of age.

21 (2) It is the intent of the Legislature that, to the extent the federal  
22 government requires BHT to be a covered Medi-Cal service, the  
23 department shall seek statutory authority to implement this new  
24 benefit in Medi-Cal.

25 (b) The department shall implement, or continue to implement,  
26 this section only after all of the following occurs or has occurred:

27 (1) The department receives all necessary federal approvals to  
28 obtain federal funds for the service.

29 (2) The department seeks an appropriation that would provide  
30 the necessary state funding estimated to be required for the  
31 applicable fiscal year.

32 (3) The department consults with stakeholders.

33 (c) The department shall develop and define eligibility criteria,  
34 provider participation criteria, utilization controls, and delivery  
35 system structure for services under this section, subject to  
36 limitations allowable under federal law, in consultation with  
37 stakeholders.

38 *(d) (1) The department, commencing on the effective date of*  
39 *the act that added this subdivision until March 31, 2017, inclusive,*  
40 *may make available to individuals described in paragraph (2)*

1 *contracted services to assist those individuals with health insurance*  
2 *enrollment, without regard to whether federal funds are available*  
3 *for the contracted services.*

4 *(2) The contracted services described in paragraph (1) may be*  
5 *provided only to an individual under 21 years of age whom the*  
6 *department identifies as no longer eligible for Medi-Cal solely*  
7 *due to the transition of BHT coverage from the waiver program*  
8 *under Section 1915(c) of the federal Social Security Act to the*  
9 *Medi-Cal state plan in accordance with this section and who meets*  
10 *all of the following criteria:*

11 *(A) He or she was enrolled in the home and community-based*  
12 *services waiver for persons with developmental disabilities under*  
13 *Section 1915(c) of the Social Security Act as of January 31, 2016.*

14 *(B) He or she was deemed to be institutionalized in order to*  
15 *establish eligibility under the terms of the waiver.*

16 *(C) He or she has not been found eligible under any other*  
17 *federally funded Medi-Cal criteria without a share of cost.*

18 *(D) He or she had received a BHT service from a regional center*  
19 *for persons with developmental disabilities as provided in Chapter*  
20 *5 (commencing with Section 4620) of Division 4.5.*

21 ~~(E)~~

22 *(e) Notwithstanding Chapter 3.5 (commencing with Section*  
23 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*  
24 *the department, without taking any further regulatory action, shall*  
25 *implement, interpret, or make specific this section by means of*  
26 *all-county letters, plan letters, plan or provider bulletins, or similar*  
27 *instructions until regulations are adopted. The department shall*  
28 *adopt regulations by July 1, 2017, in accordance with the*  
29 *requirements of Chapter 3.5 (commencing with Section 11340) of*  
30 *Part 1 of Division 3 of Title 2 of the Government Code.*  
31 *Notwithstanding Section 10231.5 of the Government Code,*  
32 *beginning six months after the effective date of this section, the*  
33 *department shall provide semiannual status reports to the*  
34 *Legislature, in compliance with Section 9795 of the Government*  
35 *Code, until regulations have been adopted.*

36 ~~(e)~~

37 *(f) For the purposes of implementing this section, the department*  
38 *may enter into exclusive or nonexclusive contracts on a bid or*  
39 *negotiated basis, including contracts for the purpose of obtaining*  
40 *subject matter expertise or other technical assistance. Contracts*

1 may be statewide or on a more limited geographic basis. Contracts  
2 entered into or amended under this subdivision shall be exempt  
3 from Part 2 (commencing with Section 10100) of Division 2 of  
4 the Public Contract ~~Code~~ *Code, Section 19130 of the Government*  
5 *Code*, and Chapter 6 (commencing with Section 14825) of Part  
6 5.5 of Division 3 of the Government Code, and shall be exempt  
7 from the review or approval of any division of the Department of  
8 General Services.

9 (f)

10 (g) The department may seek approval of any necessary state  
11 plan amendments or waivers to implement this section. The  
12 department shall make any state plan amendments or waiver  
13 requests public at least 30 days prior to submitting to the federal  
14 Centers for Medicare and Medicaid Services, and the department  
15 shall work with stakeholders to address the public comments in  
16 the state plan amendment or waiver request.

17 (g)

18 (h) This section shall be implemented only to the extent that  
19 federal financial participation is available and any necessary federal  
20 approvals have been obtained.

21 *SEC. 30. Section 14154 of the Welfare and Institutions Code*  
22 *is amended to read:*

23 14154. (a) (1) The department shall establish and maintain a  
24 plan whereby costs for county administration of the determination  
25 of eligibility for benefits under this chapter will be effectively  
26 controlled within the amounts annually appropriated for that  
27 administration. The plan, to be known as the County Administrative  
28 Cost Control Plan, shall establish standards and performance  
29 criteria, including workload, productivity, and support services  
30 standards, to which counties shall adhere. The plan shall include  
31 standards for controlling eligibility determination costs that are  
32 incurred by performing eligibility determinations at county  
33 hospitals, or that are incurred due to the outstationing of any other  
34 eligibility function. Except as provided in Section 14154.15,  
35 reimbursement to a county for outstationed eligibility functions  
36 shall be based solely on productivity standards applied to that  
37 county's welfare department office.

38 (2) (A) The plan shall delineate both of the following:

1 (i) The process for determining county administration base costs,  
2 which include salaries and benefits, support costs, and staff  
3 development.

4 (ii) The process for determining funding for caseload changes,  
5 cost-of-living adjustments, and program and other changes.

6 (B) The annual county budget survey document utilized under  
7 the plan shall be constructed to enable the counties to provide  
8 sufficient detail to the department to support their budget requests.

9 (3) The plan shall be part of a single state plan, jointly developed  
10 by the department and the State Department of Social Services, in  
11 conjunction with the counties, for administrative cost control for  
12 the California Work Opportunity and Responsibility to Kids  
13 (CalWORKs), CalFresh, and Medical Assistance (Medi-Cal)  
14 programs. Allocations shall be made to each county and shall be  
15 limited by and determined based upon the County Administrative  
16 Cost Control Plan. In administering the plan to control county  
17 administrative costs, the department shall not allocate state funds  
18 to cover county cost overruns that result from county failure to  
19 meet requirements of the plan. The department and the State  
20 Department of Social Services shall budget, administer, and  
21 allocate state funds for county administration in a uniform and  
22 consistent manner.

23 (4) The department and county welfare departments shall  
24 develop procedures to ensure the data clarity, consistency, and  
25 reliability of information contained in the county budget survey  
26 document submitted by counties to the department. These  
27 procedures shall include the format of the county budget survey  
28 document and process, data submittal and its documentation, and  
29 the use of the county budget survey documents for the development  
30 of determining county administration costs. Communication  
31 between the department and the county welfare departments shall  
32 be ongoing as needed regarding the content of the county budget  
33 surveys and any potential issues to ensure the information is  
34 complete and well understood by involved parties. Any changes  
35 developed pursuant to this section shall be incorporated within the  
36 state's annual budget process by no later than the 2011–12 fiscal  
37 year.

38 (5) The department shall provide a clear narrative description  
39 along with fiscal detail in the Medi-Cal estimate package, submitted  
40 to the Legislature in January and May of each year, of each

1 component of the county administrative funding for the Medi-Cal  
2 program. This shall describe how the information obtained from  
3 the county budget survey documents was utilized and, if applicable,  
4 modified and the rationale for the changes.

5 (6) Notwithstanding any other law, the department shall develop  
6 and implement, in consultation with county program and fiscal  
7 representatives, a new budgeting methodology for Medi-Cal county  
8 administrative costs that reflects the impact of PPACA  
9 implementation on county administrative work. The new budgeting  
10 methodology shall be used to reimburse counties for eligibility  
11 processing and case maintenance for applicants and beneficiaries.

12 (A) The budgeting methodology may include, but is not limited  
13 to, identification of the costs of eligibility determinations for  
14 applicants, and the costs of eligibility redeterminations and case  
15 maintenance activities for recipients, for different groupings of  
16 cases, based on variations in time and resources needed to conduct  
17 eligibility determinations. The calculation of time and resources  
18 shall be based on the following factors: complexity of eligibility  
19 rules, ongoing eligibility requirements, and other factors as  
20 determined appropriate by the department. The development of  
21 the new budgeting methodology may include, but is not limited  
22 to, county survey of costs, time and motion studies, in-person  
23 observations by department staff, data reporting, and other factors  
24 deemed appropriate by the department.

25 (B) The new budgeting methodology shall be clearly described,  
26 state the necessary data elements to be collected from the counties,  
27 and establish the timeframes for counties to provide the data to  
28 the state.

29 (C) The new budgeting methodology developed pursuant to this  
30 paragraph shall be implemented no sooner than the 2015–16 fiscal  
31 year. The department may develop a process for counties to phase  
32 in the requirements of the new budgeting methodology.

33 (D) The department shall provide the new budgeting  
34 methodology to the legislative fiscal committees by March 1 of  
35 the fiscal year immediately preceding the first fiscal year of  
36 implementation of the new budgeting methodology.

37 (E) To the extent that the funding for the county budgets  
38 developed pursuant to the new budget methodology is not fully  
39 appropriated in any given fiscal year, the department, with input

1 from the counties, shall identify and consider options to align  
2 funding and workload responsibilities.

3 (F) For purposes of this paragraph, “PPACA” means the federal  
4 Patient Protection and Affordable Care Act (Public Law 111-148),  
5 as amended by the federal Health Care and Education  
6 Reconciliation Act of 2010 (Public Law 111-152) and any  
7 subsequent amendments.

8 (G) Notwithstanding Chapter 3.5 (commencing with Section  
9 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
10 the department may implement, interpret, or make specific this  
11 paragraph by means of all-county letters, plan letters, plan or  
12 provider bulletins, or similar instructions until the time any  
13 necessary regulations are adopted. The department shall adopt  
14 regulations by July 1, 2017, in accordance with the requirements  
15 of Chapter 3.5 (commencing with Section 11340) of Part 1 of  
16 Division 3 of Title 2 of the Government Code. Beginning six  
17 months after the implementation of the new budgeting methodology  
18 pursuant to this paragraph, and notwithstanding Section 10231.5  
19 of the Government Code, the department shall provide a status  
20 report to the Legislature on a semiannual basis, in compliance with  
21 Section 9795 of the Government Code, until regulations have been  
22 adopted.

23 (b) Nothing in this section, Section 15204.5, or Section 18906  
24 shall be construed to limit the administrative or budgetary  
25 responsibilities of the department in a manner that would violate  
26 Section 14100.1, and thereby jeopardize federal financial  
27 participation under the Medi-Cal program.

28 (c) (1) The Legislature finds and declares that in order for  
29 counties to do the work that is expected of them, it is necessary  
30 that they receive adequate funding, including adjustments for  
31 reasonable annual cost-of-doing-business increases. The Legislature  
32 further finds and declares that linking appropriate funding for  
33 county Medi-Cal administrative operations, including annual  
34 cost-of-doing-business adjustments, with performance standards  
35 will give counties the incentive to meet the performance standards  
36 and enable them to continue to do the work they do on behalf of  
37 the state. It is therefore the Legislature’s intent to provide  
38 appropriate funding to the counties for the effective administration  
39 of the Medi-Cal program at the local level to ensure that counties

1 can reasonably meet the purposes of the performance measures as  
2 contained in this section.

3 (2) It is the intent of the Legislature to not appropriate funds for  
4 the cost-of-doing-business adjustment for the 2008–09, 2009–10,  
5 2010–11, 2011–12, 2012–13, 2014–15, ~~and 2015–16~~ 2015–16,  
6 *and 2016–17* fiscal years.

7 (d) The department is responsible for the Medi-Cal program in  
8 accordance with state and federal law. A county shall determine  
9 Medi-Cal eligibility in accordance with state and federal law. If  
10 in the course of its duties the department becomes aware of  
11 accuracy problems in any county, the department shall, within  
12 available resources, provide training and technical assistance as  
13 appropriate. Nothing in this section shall be interpreted to eliminate  
14 any remedy otherwise available to the department to enforce  
15 accurate county administration of the program. In administering  
16 the Medi-Cal eligibility process, each county shall meet the  
17 following performance standards each fiscal year:

18 (1) Complete eligibility determinations as follows:

19 (A) Ninety percent of the general applications without applicant  
20 errors and are complete shall be completed within 45 days.

21 (B) Ninety percent of the applications for Medi-Cal based on  
22 disability shall be completed within 90 days, excluding delays by  
23 the state.

24 (2) (A) The department shall establish best-practice guidelines  
25 for expedited enrollment of newborns into the Medi-Cal program,  
26 preferably with the goal of enrolling newborns within 10 days after  
27 the county is informed of the birth. The department, in consultation  
28 with counties and other stakeholders, shall work to develop a  
29 process for expediting enrollment for all newborns, including those  
30 born to mothers receiving CalWORKs assistance.

31 (B) Upon the development and implementation of the  
32 best-practice guidelines and expedited processes, the department  
33 and the counties may develop an expedited enrollment timeframe  
34 for newborns that is separate from the standards for all other  
35 applications, to the extent that the timeframe is consistent with  
36 these guidelines and processes.

37 (3) Perform timely annual redeterminations, as follows:

38 (A) Ninety percent of the annual redetermination forms shall  
39 be mailed to the recipient by the anniversary date.

1 (B) Ninety percent of the annual redeterminations shall be  
2 completed within 60 days of the recipient's annual redetermination  
3 date for those redeterminations based on forms that are complete  
4 and have been returned to the county by the recipient in a timely  
5 manner.

6 (C) Ninety percent of those annual redeterminations where the  
7 redetermination form has not been returned to the county by the  
8 recipient shall be completed by sending a notice of action to the  
9 recipient within 45 days after the date the form was due to the  
10 county.

11 ~~(D) If a child is determined by the county to change from no~~  
12 ~~share of cost to a share of cost and the child meets the eligibility~~  
13 ~~criteria for the Healthy Families Program established under Section~~  
14 ~~12693.98 of the Insurance Code, the child shall be placed in the~~  
15 ~~Medi-Cal-to-Healthy Families Bridge Benefits Program, and these~~  
16 ~~cases shall be processed as follows:~~

17 (i) Ninety percent of the families of these children shall be sent  
18 a notice informing them of the Healthy Families Program within  
19 five working days from the determination of a share of cost.

20 (ii) Ninety percent of all annual redetermination forms for these  
21 children shall be sent to the Healthy Families Program within five  
22 working days from the determination of a share of cost if the parent  
23 has given consent to send this information to the Healthy Families  
24 Program.

25 (iii) Ninety percent of the families of these children placed in  
26 the Medi-Cal-to-Healthy Families Bridge Benefits Program who  
27 have not consented to sending the child's annual redetermination  
28 form to the Healthy Families Program shall be sent a request,  
29 within five working days of the determination of a share of cost,  
30 to consent to send the information to the Healthy Families Program.

31 ~~(E) Subparagraph (D) shall not be implemented until 60 days~~  
32 ~~after the Medi-Cal and Joint Medi-Cal and Healthy Families~~  
33 ~~applications and the Medi-Cal redetermination forms are revised~~  
34 ~~to allow the parent of a child to consent to forward the child's~~  
35 ~~information to the Healthy Families Program.~~

36 (e) The department shall develop procedures in collaboration  
37 with the counties and stakeholder groups for determining county  
38 review cycles, sampling methodology and procedures, and data  
39 reporting.

1 (f) On January 1 of each year, each applicable county, as  
2 determined by the department, shall report to the department on  
3 the county's results in meeting the performance standards specified  
4 in this section. The report shall be subject to verification by the  
5 department. County reports shall be provided to the public upon  
6 written request.

7 (g) If the department finds that a county is not in compliance  
8 with one or more of the standards set forth in this section, the  
9 county shall, within 60 days, submit a corrective action plan to the  
10 department for approval. The corrective action plan shall, at a  
11 minimum, include steps that the county shall take to improve its  
12 performance on the standard or standards with which the county  
13 is out of compliance. The plan shall establish interim benchmarks  
14 for improvement that shall be expected to be met by the county in  
15 order to avoid a sanction.

16 (h) (1) If a county does not meet the performance standards for  
17 completing eligibility determinations and redeterminations as  
18 specified in this section, the department may, at its sole discretion,  
19 reduce the allocation of funds to that county in the following year  
20 by 2 percent. Any funds so reduced may be restored by the  
21 department if, in the determination of the department, sufficient  
22 improvement has been made by the county in meeting the  
23 performance standards during the year for which the funds were  
24 reduced. If the county continues not to meet the performance  
25 standards, the department may reduce the allocation by an  
26 additional 2 percent for each year thereafter in which sufficient  
27 improvement has not been made to meet the performance standards.

28 (2) No reduction of the allocation of funds to a county shall be  
29 imposed pursuant to this subdivision for failure to meet  
30 performance standards during any period of time in which the  
31 cost-of-doing-business increase is suspended.

32 ~~(i) The department shall develop procedures, in collaboration~~  
33 ~~with the counties and stakeholders, for developing instructions for~~  
34 ~~the performance standards established under subparagraph (D) of~~  
35 ~~paragraph (3) of subdivision (d), no later than September 1, 2005.~~

36 ~~(j) No later than September 1, 2005, the department shall issue~~  
37 ~~a revised annual redetermination form to allow a parent to indicate~~  
38 ~~parental consent to forward the annual redetermination form to~~  
39 ~~the Healthy Families Program if the child is determined to have a~~  
40 ~~share of cost.~~

~~(k) The department, in coordination with the Managed Risk Medical Insurance Board, shall streamline the method of providing the Healthy Families Program with information necessary to determine Healthy Families eligibility for a child who is receiving services under the Medi-Cal-to-Healthy Families Bridge Benefits Program.~~

~~(l)~~

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and except as provided in subparagraph (G) of paragraph (6) of subdivision (a), the department shall, without taking any further regulatory action, implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters or similar instructions.

*SEC. 31. Section 14301.1 of the Welfare and Institutions Code, as amended by Section 28 of Chapter 37 of the Statutes of 2013, is amended to read:*

14301.1. (a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan- and county-specific rates. Notwithstanding any other law, this section shall apply to any managed care organization, licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), that has contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS for rates established on or after July 1, 2012. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

(1) Health-plan-specific encounter and claims data.

(2) Supplemental utilization and cost data submitted by the health plans.

1 (3) Fee-for-service data for the underlying county of operation  
2 or other appropriate counties as deemed necessary by the  
3 department.

4 (4) Department of Managed Health Care financial statement  
5 data specific to Medi-Cal operations.

6 (5) Other demographic factors, such as age, gender, or  
7 diagnostic-based risk adjustments, as the department deems  
8 appropriate.

9 (b) To the extent that the department is unable to obtain  
10 sufficient actual plan data, it may substitute plan model, similar  
11 plan, or county-specific fee-for-service data.

12 (c) The department shall develop rates that include  
13 administrative costs, and may apply different administrative costs  
14 with respect to separate aid code groups.

15 (d) The department shall develop rates that shall include, but  
16 are not limited to, assumptions for underwriting, return on  
17 investment, risk, contingencies, changes in policy, and a detailed  
18 review of health plan financial statements to validate and reconcile  
19 costs for use in developing rates.

20 (e) The department may develop rates that pay plans based on  
21 performance incentives, including quality indicators, access to  
22 care, and data submission.

23 (f) The department may develop and adopt condition-specific  
24 payment rates for health conditions, including, but not limited to,  
25 childbirth delivery.

26 (g) (1) Prior to finalizing Medi-Cal managed care capitation  
27 rates, the department shall provide health plans with information  
28 on how the rates were developed, including rate sheets for that  
29 specific health plan, and provide the plans with the opportunity to  
30 provide additional supplemental information.

31 (2) For contracts entered into between the department and any  
32 entity pursuant to Article 2.8 (commencing with Section 14087.5)  
33 of Chapter 7, the department, by June 30 of each year, or, if the  
34 budget has not passed by that date, no later than five working days  
35 after the budget is signed, shall provide preliminary rates for the  
36 upcoming fiscal year.

37 (h) For the purposes of developing capitation rates through  
38 implementation of this ratesetting methodology, Medi-Cal managed  
39 care health plans shall provide the department with financial and  
40 utilization data in a form and substance as deemed necessary by

1 the department to establish rates. This data shall be considered  
2 proprietary and shall be exempt from disclosure as official  
3 information pursuant to subdivision (k) of Section 6254 of the  
4 Government Code as contained in the California Public Records  
5 Act (Division 7 (commencing with Section 6250) of Title 1 of the  
6 Government Code).

7 (i) Notwithstanding any other ~~provision of law~~, on and after the  
8 effective date of the act adding this subdivision, the department  
9 may apply this section to the capitation rates it pays under any  
10 managed care health plan contract.

11 (j) Notwithstanding Chapter 3.5 (commencing with Section  
12 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
13 the department may set and implement managed care capitation  
14 rates, and interpret or make specific this section and any applicable  
15 federal waivers and state plan amendments by means of plan letters,  
16 plan or provider bulletins, or similar instructions, without taking  
17 regulatory action.

18 (k) The department shall report, upon request, to the fiscal and  
19 policy committees of the respective houses of the Legislature  
20 regarding implementation of this section.

21 (l) Prior to October 1, 2011, the risk-adjusted countywide  
22 capitation rate shall comprise no more than 20 percent of the total  
23 capitation rate paid to each Medi-Cal managed care plan.

24 (m) (1) It is the intent of the Legislature to preserve the policy  
25 goal to support and strengthen traditional safety net providers who  
26 treat high volumes of uninsured and Medi-Cal patients when  
27 Medi-Cal enrollees are defaulted into Medi-Cal managed care  
28 plans.

29 (2) As the department adds additional factors, such as managed  
30 care plan costs, to the Medi-Cal managed care plan default  
31 assignment algorithm, it shall consult with the Auto Assignment  
32 Performance Incentive Program stakeholder workgroup to develop  
33 cost factor disregards related to intergovernmental transfers and  
34 required wraparound payments that support safety net providers.

35 (n) (1) *The department shall develop and pay capitation rates*  
36 *to entities contracted pursuant to Chapter 8.75 (commencing with*  
37 *Section 14591), using actuarial methods and in a manner consistent*  
38 *with this section, except as provided in this subdivision.*

39 (2) *The department may develop capitation rates using a*  
40 *standardized rate methodology across managed care plan models*

1 *for comparable populations. The specific rate methodology applied*  
2 *to PACE organizations shall address features of PACE that*  
3 *distinguishes it from other managed care plan models.*

4 *(3) The department may develop statewide rates and apply*  
5 *geographic adjustments, using available data sources deemed*  
6 *appropriate by the department. Consistent with actuarial methods,*  
7 *the primary source of data used to develop rates for each PACE*  
8 *organization shall be its Medi-Cal cost and utilization data or*  
9 *other data sources as deemed necessary by the department.*

10 *(4) Rates developed pursuant to this subdivision shall reflect*  
11 *the level of care associated with the specific populations served*  
12 *under the contract.*

13 *(5) The rate methodology developed pursuant to this subdivision*  
14 *shall contain a mechanism to account for the costs of high-cost*  
15 *drugs and treatments.*

16 *(6) Rates developed pursuant to this subdivision shall be*  
17 *actuarially certified prior to implementation.*

18 *(7) The department shall consult with those entities contracted*  
19 *pursuant to Chapter 8.75 (commencing with Section 14591) in*  
20 *developing a rate methodology according to this subdivision.*

21 *(8) Consistent with the requirements of federal law, the*  
22 *department shall calculate an upper payment limit for payments*  
23 *to PACE organizations. In calculating the upper payment limit,*  
24 *the department shall correct the applicable data as necessary and*  
25 *shall consider the risk of nursing home placement for the*  
26 *comparable population when estimating the level of care and risk*  
27 *of PACE participants.*

28 *(9) During the first three rate years in which the methodology*  
29 *developed pursuant to this subdivision is used by the department*  
30 *to set rates for entities contracted pursuant to Chapter 8.75*  
31 *(commencing with Section 14591), the department shall pay the*  
32 *entity at a rate within the certified actuarially sound rate range*  
33 *developed with respect to that entity, to the extent consistent with*  
34 *federal requirements and subject to paragraph (11), as necessary*  
35 *to mitigate the impact to the entity during the transition to the*  
36 *methodology developed pursuant to this subdivision.*

37 *(10) During the first two years in which a new PACE*  
38 *organization or existing PACE organization enters a previously*  
39 *unserved area, the department shall pay at a rate within the*  
40 *certified actuarially sound rate range developed with respect to*

1 *that entity, to the extent consistent with federal requirements and*  
2 *subject to paragraph (11).*

3 *(11) This subdivision shall be implemented only to the extent*  
4 *that any necessary federal approvals are obtained and federal*  
5 *financial participation is available.*

6 *(12) This subdivision shall apply for rates implemented no*  
7 *earlier than January 1, 2017.*

8 ~~(n)~~

9 *(o) This section shall be inoperative if the Coordinated Care*  
10 *Initiative becomes inoperative pursuant to Section 34 of the act*  
11 *that added this subdivision. Chapter 37 of the Statutes of 2013.*

12 *SEC. 32. Section 14301.1 of the Welfare and Institutions Code,*  
13 *as added by Section 29 of Chapter 37 of the Statutes of 2013, is*  
14 *amended to read:*

15 14301.1. (a) For rates established on or after August 1, 2007,  
16 the department shall pay capitation rates to health plans  
17 participating in the Medi-Cal managed care program using actuarial  
18 methods and may establish health-plan- and county-specific rates.  
19 The department shall utilize a county- and model-specific rate  
20 methodology to develop Medi-Cal managed care capitation rates  
21 for contracts entered into between the department and any entity  
22 pursuant to Article 2.7 (commencing with Section 14087.3), Article  
23 2.8 (commencing with Section 14087.5), and Article 2.91  
24 (commencing with Section 14089) of Chapter 7 that includes, but  
25 is not limited to, all of the following:

26 (1) Health-plan-specific encounter and claims data.

27 (2) Supplemental utilization and cost data submitted by the  
28 health plans.

29 (3) Fee-for-service data for the underlying county of operation  
30 or other appropriate counties as deemed necessary by the  
31 department.

32 (4) Department of Managed Health Care financial statement  
33 data specific to Medi-Cal operations.

34 (5) Other demographic factors, such as age, gender, or  
35 diagnostic-based risk adjustments, as the department deems  
36 appropriate.

37 (b) To the extent that the department is unable to obtain  
38 sufficient actual plan data, it may substitute plan model, similar  
39 plan, or county-specific fee-for-service data.

1 (c) The department shall develop rates that include  
2 administrative costs, and may apply different administrative costs  
3 with respect to separate aid code groups.

4 (d) The department shall develop rates that shall include, but  
5 are not limited to, assumptions for underwriting, return on  
6 investment, risk, contingencies, changes in policy, and a detailed  
7 review of health plan financial statements to validate and reconcile  
8 costs for use in developing rates.

9 (e) The department may develop rates that pay plans based on  
10 performance incentives, including quality indicators, access to  
11 care, and data submission.

12 (f) The department may develop and adopt condition-specific  
13 payment rates for health conditions, including, but not limited to,  
14 childbirth delivery.

15 (g) (1) Prior to finalizing Medi-Cal managed care capitation  
16 rates, the department shall provide health plans with information  
17 on how the rates were developed, including rate sheets for that  
18 specific health plan, and provide the plans with the opportunity to  
19 provide additional supplemental information.

20 (2) For contracts entered into between the department and any  
21 entity pursuant to Article 2.8 (commencing with Section 14087.5)  
22 of Chapter 7, the department, by June 30 of each year, or, if the  
23 budget has not passed by that date, no later than five working days  
24 after the budget is signed, shall provide preliminary rates for the  
25 upcoming fiscal year.

26 (h) For the purposes of developing capitation rates through  
27 implementation of this ratesetting methodology, Medi-Cal managed  
28 care health plans shall provide the department with financial and  
29 utilization data in a form and substance as deemed necessary by  
30 the department to establish rates. This data shall be considered  
31 proprietary and shall be exempt from disclosure as official  
32 information pursuant to subdivision (k) of Section 6254 of the  
33 Government Code as contained in the California Public Records  
34 Act (Division 7 (commencing with Section 6250) of Title 1 of the  
35 Government Code).

36 (i) The department shall report, upon request, to the fiscal and  
37 policy committees of the respective houses of the Legislature  
38 regarding implementation of this section.

1 (j) Prior to October 1, 2011, the risk-adjusted countywide  
2 capitation rate shall comprise no more than 20 percent of the total  
3 capitation rate paid to each Medi-Cal managed care plan.

4 (k) (1) It is the intent of the Legislature to preserve the policy  
5 goal to support and strengthen traditional safety net providers who  
6 treat high volumes of uninsured and Medi-Cal patients when  
7 Medi-Cal enrollees are defaulted into Medi-Cal managed care  
8 plans.

9 (2) As the department adds additional factors, such as managed  
10 care plan costs, to the Medi-Cal managed care plan default  
11 assignment algorithm, it shall consult with the Auto Assignment  
12 Performance Incentive Program stakeholder workgroup to develop  
13 cost factor disregards related to intergovernmental transfers and  
14 required wraparound payments that support safety net providers.

15 *(l) (1) The department shall develop and pay capitation rates*  
16 *to entities contracted pursuant to Chapter 8.75 (commencing with*  
17 *Section 14591), using actuarial methods and in a manner consistent*  
18 *with this section, except as provided in this subdivision.*

19 *(2) The department may develop capitation rates using a*  
20 *standardized rate methodology across managed care plan models*  
21 *for comparable populations. The specific rate methodology applied*  
22 *to PACE organizations shall address features of PACE that*  
23 *distinguish it from other managed care plan models.*

24 *(3) The department may develop statewide rates and apply*  
25 *geographic adjustments, using available data sources deemed*  
26 *appropriate by the department. Consistent with actuarial methods,*  
27 *the primary source of data used to develop rates for each PACE*  
28 *organization shall be its Medi-Cal cost and utilization data or*  
29 *other data sources as deemed necessary by the department.*

30 *(4) Rates developed pursuant to this subdivision shall reflect*  
31 *the level of care associated with the specific populations served*  
32 *under the contract.*

33 *(5) The rate methodology developed pursuant to this subdivision*  
34 *shall contain a mechanism to account for the costs of high-cost*  
35 *drugs and treatments.*

36 *(6) Rates developed pursuant to this subdivision shall be*  
37 *actuarially certified prior to implementation.*

38 *(7) The department shall consult with those entities contracted*  
39 *pursuant to Chapter 8.75 (commencing with Section 14591) in*  
40 *developing a rate methodology according to this subdivision.*

1 (8) Consistent with the requirements of federal law, the  
2 department shall calculate an upper payment limit for payments  
3 to PACE organizations. In calculating the upper payment limit,  
4 the department shall correct the applicable data as necessary and  
5 shall consider the risk of nursing home placement for the  
6 comparable population when estimating the level of care and risk  
7 of PACE participants.

8 (9) During the first three rate years in which the methodology  
9 developed pursuant to this subdivision is used by the department  
10 to set rates for entities contracted pursuant to Chapter 8.75  
11 (commencing with Section 14591), the department shall pay the  
12 entity at a rate within the certified actuarially sound rate range  
13 developed with respect to that entity, to the extent consistent with  
14 federal requirements and subject to paragraph (11), as necessary  
15 to mitigate the impact to the entity during the transition to the  
16 methodology developed pursuant to this subdivision.

17 (10) During the first two years in which a new PACE  
18 organization or existing PACE organization enters a previously  
19 unserved area, the department shall pay at a rate within the  
20 certified actuarially sound rate range developed with respect to  
21 that entity, to the extent consistent with federal requirements and  
22 subject to paragraph (11).

23 (11) This subdivision shall be implemented only to the extent  
24 any necessary federal approvals are obtained and federal financial  
25 participation is available.

26 (12) This subdivision shall apply for rates implemented no  
27 earlier than January 1, 2017.

28 (t)

29 (m) This section shall be operative only if Section 28 of the act  
30 that added this section Chapter 37 of the Statutes of 2013 becomes  
31 inoperative pursuant to subdivision (n) of that Section 28.

32 SEC. 33. Section 14592 of the Welfare and Institutions Code  
33 is amended to read:

34 14592. (a) For purposes of this chapter, "PACE organization"  
35 means an entity as defined in Section 460.6 of Title 42 of the Code  
36 of Federal Regulations.

37 (b) The Director of Health Care Services shall establish the  
38 California Program of All-Inclusive Care for the Elderly, to provide  
39 community-based, risk-based, and capitated long-term care services  
40 as optional services under the state's Medi-Cal State Plan and

1 under contracts entered into between the federal Centers for  
2 Medicare and Medicaid Services, the department, and PACE  
3 organizations, meeting the requirements of the Balanced Budget  
4 Act of 1997 (Public Law 105-33) and ~~Part 460 (commencing with~~  
5 ~~Section 460.2) of Title 42 of the Code of Federal Regulations; any~~  
6 *other applicable law or regulation.*

7 *SEC. 34. Section 14593 of the Welfare and Institutions Code*  
8 *is amended to read:*

9 14593. (a) (1) The department may enter into contracts with  
10 public or private ~~nonprofit~~ organizations for implementation of  
11 the PACE program, and also may enter into separate contracts  
12 with PACE organizations, to fully implement the single state  
13 agency responsibilities assumed by the department in those  
14 contracts, Section 14132.94, and any other state requirement found  
15 necessary by the department to provide comprehensive  
16 community-based, risk-based, and capitated long-term care services  
17 to California's frail elderly.

18 (2) The department may enter into separate contracts as specified  
19 in ~~subdivision (a) paragraph (1)~~ with up to 15 PACE organizations.  
20 *This paragraph shall become inoperative upon federal approval*  
21 *of a capitation rate methodology, pursuant to subdivision (n) of*  
22 *Section 14301.1.*

23 (b) The requirements of the PACE model, as provided for  
24 pursuant to Section 1894 (42 U.S.C. Sec. 1395eee) and Section  
25 1934 (42 U.S.C. Sec. 1396u-4) of the federal Social Security Act,  
26 shall not be waived or modified. The requirements that shall not  
27 be waived or modified include all of the following:

28 (1) The focus on frail elderly qualifying individuals who require  
29 the level of care provided in a nursing facility.

30 (2) The delivery of comprehensive, integrated acute and  
31 long-term care services.

32 (3) The interdisciplinary team approach to care management  
33 and service delivery.

34 (4) Capitated, integrated financing that allows the provider to  
35 pool payments received from public and private programs and  
36 individuals.

37 (5) The assumption by the provider of full financial risk.

38 (6) The provision of a PACE benefit package for all participants,  
39 regardless of source of payment, that shall include all of the  
40 following:

1 (A) All Medicare-covered items and services.

2 (B) All Medicaid-covered items and services, as specified in  
3 the state's Medicaid plan.

4 (C) Other services determined necessary by the interdisciplinary  
5 team to improve and maintain the participant's overall health status.

6 (c) Sections 14002, 14005.12, 14005.17, and 14006 shall apply  
7 when determining the eligibility for Medi-Cal of a person receiving  
8 the services from an organization providing services under this  
9 chapter.

10 (d) Provisions governing the treatment of income and resources  
11 of a married couple, for the purposes of determining the eligibility  
12 of a nursing-facility certifiable or institutionalized spouse, shall  
13 be established so as to qualify for federal financial participation.

14 (e) (1) The department shall establish capitation rates paid to  
15 each PACE organization at no less than 95 percent of the  
16 fee-for-service equivalent cost, including the department's cost of  
17 administration, that the department estimates would be payable  
18 for all services covered under the PACE organization contract if  
19 all those services were to be furnished to Medi-Cal beneficiaries  
20 under the fee-for-service Medi-Cal program provided for pursuant  
21 to Chapter 7 (commencing with Section 14000).

22 (2) This subdivision shall be implemented only to the extent  
23 that federal financial participation is available.

24 (3) *This subdivision shall become inoperative upon federal*  
25 *approval of a capitation rate methodology, pursuant to subdivision*  
26 *(n) of Section 14301.1.*

27 (f) Contracts under this chapter may be on a nonbid basis and  
28 shall be exempt from Chapter 2 (commencing with Section 10290)  
29 of Part 2 of Division 2 of the Public Contract Code.

30 ~~(g) This section shall become operative on April 1, 2015.~~

31 (g) (1) *Notwithstanding subdivision (b), and only to the extent*  
32 *federal financial participation is available, the department, in*  
33 *consultation with PACE organizations, shall seek increased federal*  
34 *regulatory flexibility from the federal Centers for Medicare and*  
35 *Medicaid Services to modernize the PACE program, which may*  
36 *include, but is not limited to, addressing all of the following:*

37 (A) *Composition of PACE interdisciplinary teams (IDT).*

38 (B) *Use of community-based physicians.*

39 (C) *Marketing practices.*

40 (D) *Development of a streamlined PACE waiver process.*

1     (2) *This subdivision shall be operative upon federal approval*  
2 *of a capitation rate methodology pursuant to subdivision (n) of*  
3 *Section 14301.1.*

4     (h) *This section shall become inoperative if the Coordinated*  
5 *Care Initiative becomes inoperative pursuant to Section 34 of*  
6 *Chapter 37 of the Statutes of 2013 and shall be repealed on*  
7 *January 1 next following the date upon which it becomes*  
8 *inoperative.*

9     SEC. 35. *Section 14593 is added to the Welfare and Institutions*  
10 *Code, to read:*

11     14593. (a) (1) *The department may enter into contracts with*  
12 *public or private organizations for implementation of the PACE*  
13 *program, and also may enter into separate contracts with PACE*  
14 *organizations, to fully implement the single state agency*  
15 *responsibilities assumed by the department in those contracts,*  
16 *Section 14132.94, and any other state requirement found necessary*  
17 *by the department to provide comprehensive community-based,*  
18 *risk-based, and capitated long-term care services to California's*  
19 *frail elderly.*

20     (2) *The department may enter into separate contracts as*  
21 *specified in paragraph (1) with up to 15 PACE organizations. This*  
22 *paragraph shall become inoperative upon federal approval of a*  
23 *capitation rate methodology pursuant to subdivision (l) of Section*  
24 *14301.1.*

25     (b) *The requirements of the PACE model, as provided for*  
26 *pursuant to Section 1894 (42 U.S.C. Sec. 1395eee) and Section*  
27 *1934 (42 U.S.C. Sec. 1396u-4) of the federal Social Security Act,*  
28 *shall not be waived or modified. The requirements that shall not*  
29 *be waived or modified include all of the following:*

30     (1) *The focus on frail elderly qualifying individuals who require*  
31 *the level of care provided in a nursing facility.*

32     (2) *The delivery of comprehensive, integrated acute and*  
33 *long-term care services.*

34     (3) *The interdisciplinary team approach to care management*  
35 *and service delivery.*

36     (4) *Capitated, integrated financing that allows the provider to*  
37 *pool payments received from public and private programs and*  
38 *individuals.*

39     (5) *The assumption by the provider of full financial risk.*

1     (6) *The provision of a PACE benefit package for all participants,*  
2 *regardless of source of payment, that shall include all of the*  
3 *following:*

4     (A) *All Medicare-covered items and services.*

5     (B) *All Medicaid-covered items and services, as specified in the*  
6 *state's Medicaid plan.*

7     (C) *Other services determined necessary by the interdisciplinary*  
8 *team to improve and maintain the participant's overall health*  
9 *status.*

10    (c) *Sections 14002, 14005.12, 14005.17, and 14006 shall apply*  
11 *when determining the eligibility for Medi-Cal of a person receiving*  
12 *the services from an organization providing services under this*  
13 *chapter.*

14    (d) *Provisions governing the treatment of income and resources*  
15 *of a married couple, for the purposes of determining the eligibility*  
16 *of a nursing-facility certifiable or institutionalized spouse, shall*  
17 *be established so as to qualify for federal financial participation.*

18    (e) (1) *The department shall establish capitation rates paid to*  
19 *each PACE organization at no less than 95 percent of the*  
20 *fee-for-service equivalent cost, including the department's cost of*  
21 *administration, that the department estimates would be payable*  
22 *for all services covered under the PACE organization contract if*  
23 *all those services were to be furnished to Medi-Cal beneficiaries*  
24 *under the fee-for-service Medi-Cal program provided for pursuant*  
25 *to Chapter 7 (commencing with Section 14000).*

26    (2) *This subdivision shall be implemented only to the extent that*  
27 *federal financial participation is available.*

28    (3) *This subdivision shall become inoperative upon federal*  
29 *approval of a capitation rate methodology pursuant to subdivision*  
30 *(1) of Section 14301.1.*

31    (f) *Contracts under this chapter may be on a nonbid basis and*  
32 *shall be exempt from Chapter 2 (commencing with Section 10290)*  
33 *of Part 2 of Division 2 of the Public Contract Code.*

34    (g) (1) *Notwithstanding subdivision (b), and only to the extent*  
35 *federal financial participation is available, the department, in*  
36 *consultation with PACE organizations, shall seek increased federal*  
37 *regulatory flexibility from the federal Centers for Medicare and*  
38 *Medicaid Services to modernize the PACE program, which may*  
39 *include, but is not limited to, addressing:*

40    (A) *Composition of PACE interdisciplinary teams (IDT).*

1 (B) *Use of community-based physicians.*

2 (C) *Marketing practices.*

3 (D) *Development of a streamlined PACE waiver process.*

4 (2) *This subdivision shall be operative upon federal approval*  
5 *of a capitation rate methodology pursuant to subdivision (l) of*  
6 *Section 14301.1.*

7 (h) *This section shall become operative only if Section 28 of*  
8 *Chapter 37 of the Statutes of 2013 becomes inoperative.*

9 SEC. 36. *The amendments made to Section 14131.10 of the*  
10 *Welfare and Institutions Code by this act shall become operative*  
11 *on July 1, 2016.*

12 SEC. 37. *This act is a bill providing for appropriations related*  
13 *to the Budget Bill within the meaning of subdivision (e) of Section*  
14 *12 of Article IV of the California Constitution, has been identified*  
15 *as related to the budget in the Budget Bill, and shall take effect*  
16 *immediately.*

17 SECTION 1. ~~It is the intent of the Legislature to enact statutory~~  
18 ~~changes relating to the 2016 Budget Act.~~

19  
20  
21 CORRECTIONS:

22 Heading—Lines 1, 2, 3, 4, and 5.  
23